



Dr Maria O’Kane
Chief Executive of SHSCT
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

4 May 2022

Dear Dr O’Kane,

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

**Provision of a Section 21 Notice requiring the provision of evidence in the
form of a written statement & Disclosure of Documents**

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

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

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

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

The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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

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

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. This Notice however requests any additional documentation relevant to TOR E which is within the custody or power of the Trust and has not been provided to us to date.

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

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

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

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

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

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

Yours faithfully

[Personal Information redacted by the USI]

Anne Donnelly

Solicitor to the Urology Services Inquiry

Tel: [Personal Information redacted by the USI]

Mobile: [Personal Information redacted by the USI]

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

Chair's Notice

[No 51 of 2022]

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

WARNING

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

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

TO:

**Dr. Maria O’Kane
Chief Executive of SHSCT
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ**

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.
2. The Notice requires you to do the acts set out in the body of the Notice.
3. You should read this Notice carefully and consult a solicitor as soon as possible about it.
4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.
5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 15th June 2022**.

APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 8th June 2022**.

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

Dated this day 4th May 2022

Signed:

Personal information redacted by the USI

Christine Smith QC

Chair of Urology Services Inquiry



SCHEDULE
[No 51 of 2022]

1. You are referred to the terms of reference of the Urology Services Inquiry ("USI"). Provide all documents within the custody or under the control of the Southern Health and Social Care Trust ("the Trust") relating to paragraph (e) of those terms of reference, except where those documents have previously been provided to the Inquiry by the Trust. If those documents have previously been provided, you are asked to draw the Inquiry's attention to the documents which specifically relate to paragraph (e) of the terms of reference.

Implementation of MHPS Framework

2. The Trust or its predecessor was required by a Department of Health circular (dated 30 November 2005) to provide notification by 31st January 2006 of all actions taken to implement the framework in *"Maintaining High Professional Standards in the Modern HPSS; A framework for handling of concerns about doctors and dentists in the HPSS"* ("MHPS"). Provide a copy of this notification and all associated documentation.
3. Provide a copy of any forerunner (or any earlier iteration) of the Trust's internal policy, *"Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance"* dated 23 September 2010 ("the 2010 Guidelines").
4. Provide a copy of the document referred to at paragraph 1.8 of the 2010 Guidelines at Annex D, namely *"SHSCT Clinical Manager's MHPS Toolkit"*.
5. Provide copies of all consultations, reviews and documentation outlining the decision making process which led to the amendment and updating of the 2010 Guidelines and the production and implementation of the Trust's internal policy, *"Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance"* dated October 2017 ("the 2017 Guidelines").

6. Provide a copy of the Trust's internal appeal process relating to clinical performance cases as required by Section IV paragraph 20 of MHPS.
7. With regard to Section I paragraph 8 of MHPS:
 - I. Outline the manner and the processes by which all concerns are to be registered with the Chief Executive.
 - II. Provide all records of this registration with regard to the concerns which arose in connection with Mr. Aidan O'Brien.
 - III. Please confirm whether concerns regarding Mr. Aidan O'Brien were brought to the attention of the Chief Executive during the period March – December 2016. If so, please provide all relevant records with regard to same.
8. With regard to Section I paragraph 29 of MHPS;
 - I. Outline the systems within the Trust which established the clear audit route for initiating and tracking the progress, cost and resulting action with regard to an investigation under Section I of MHPS.
 - II. Provide evidence of what steps the Trust undertook to audit the investigation conducted in relation to Mr. Aidan O'Brien under Section I of MHPS, with particular reference to the progress of the investigation, the cost and resulting action.

Training with regard to MHPS

9. With regard to Section VI paragraph 1 of MHPS, outline the training, guidance or support provided by the Trust for the handling of concerns and implementation of the MHPS Framework to those with specific roles under MHPS and the 2010 and 2017 Guidelines. Your answer should address the training provided to;
 - I. Clinical Managers
 - II. Case Managers
 - III. Case Investigators

- IV. Chief Executives
 - V. Designated Board Members
 - VI. HR Staff
 - VII. Service Directors and Assistant Directors
10. Outline the training, guidance or support, if any, which was provided by the Trust to each of the following individuals in relation to the handling of concerns and the implementation of the MHPS Framework in respect of Mr. Aidan O'Brien:
- I. Mr. O'Brien's clinical managers at all levels within the organisation including Mr. Mackle, Dr McAllister, Mr. Haynes, Dr Wright and any other person who filled the role of clinical manager for Mr. O'Brien
 - II. Dr Ahmed Khan (Case Manager)
 - III. Mr. Colin Weir and Dr Neta Chada (Case Investigators)
 - IV. The Chief Executive in office at all relevant times
 - V. Mr. John Wilkinson (Designated Board Member)
 - VI. Ms. Siobhan Hynds and Ms Lynne Hainey (HR Staff)
 - VII. Ms Esther Gishkori, Mr Ronan Carroll, Ms Vivienne Toal, Mr Simon Gibson, Mr Malcolm Clegg, Ms Tracey Boyce and Ms Anne McVey (Attendees at Oversight Committee meetings)

2010 Guidelines

- 11. Provide copies of any further guidance which may have been formulated by the Trust and offered to Clinical Managers and/or nominated HR Case Managers regarding the conduct of a *"screening process"* or *"initial verification"* process when concerns first arise, other than that referred to at Section 2 of the 2010 Guidelines.
- 12. Provide copies of all policies and guidance relating to the establishment, role and functioning of the 'Oversight Group,' as referred to at paragraph 2.5 of the 2010 Guidelines.

13. With regard to paragraph 3.3 of the 2010 Guidelines, outline the procedures in place to ensure that the findings of informal and formal stages are recorded and available to appraisers. Further, in answering this question you are also expected to outline any procedures which are or were in place for monitoring or ensuring the consideration and reflection of such findings at appraisal. If such procedures were not in place at the conclusion of the MHPS investigation relating to Mr O'Brien you should say so, and indicate when, if at all, the procedure was introduced.
14. With regard to paragraph 3.4 of the 2010 Guidelines, provide copies of any presentation to SMT Governance by the Medical Director and Operational Director concerning the investigation conducted into Mr Aidan O'Brien. Should no presentation have taken place, please outline the reasons why, and provide any document recording those reasons.

Effectiveness of MHPS

15. Provide any further relevant documentation, guidance or evidence with regard to the implementation and effectiveness of MHPS by the Trust generally and, specifically, concerning the investigation conducted into Mr Aidan O'Brien. If the Trust has communicated with any other organization in respect of these matters, such documentation should be provided.

NOTE:

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



UROLOGY SERVICES INQUIRY

USI Ref: Notice 51 of 2022

Date of Notice: 4th May 2022

Witness Statement of: Dr Ellen Maria O’Kane

I, Ellen Maria O’Kane, will say as follows:-

1. You are referred to the terms of reference of the Urology Services Inquiry (“USI”).

Provide all documents within the custody or under the control of the Southern Health and Social Care Trust (“the Trust”) relating to paragraph (e) of those terms of reference, except where those documents have previously been provided to the Inquiry by the Trust. If those documents have previously been provided, you are asked to draw the Inquiry’s attention to the documents which specifically relate to paragraph (e) of the terms of reference.

1.1 All documents relevant to this Section 21 Notice can be located at S21 51 of 2022 Attachments.

Implementation of MHPS Framework

2. The Trust or its predecessor was required by a Department of Health circular (dated 30 November 2005) to provide notification by 31st January 2006 of all actions taken to implement the framework in “Maintaining High Professional Standards in the Modern HPSS; A framework for handling of concerns about doctors and dentists in the HPSS” (“MHPS”). Provide a copy of this notification and all associated documentation.



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2.1 I understand that I am being asked to respond to this Section 21 Notice as Chief Executive, and not as Medical Director, of the Southern HSC Trust. In the circumstances, and given that several of the questions relate to the period prior to my tenure as Chief Executive, I have sought assistance from the following persons within the Trust in compiling my answers:

2.2

Name and Role	Questions	Comments
Mrs Vivienne Toal Director HROD	2,5,6,7,8, 9,10, 2,13,14,15	Mrs Toal, through discussions, provided me with the history of the development of the 2010 and 2017 Trust Guidance on MHPS.
Mr Shane Devlin Previous Chief Executive	7	Mr Devlin and I had discussed this before his departure on 14 th February 2022.
Mrs Zoe Parks Head of Service Medical HR	2,4,5,7, 8, 9,10, 12,13,14,15	Mrs Parks provided me with the information on the development of the Doctors and Dentists' Oversight Group. Mrs Parks also provided me with the history of the development of the Medical Director's Office and the development of reports to Trust Board, Senior Management Team, and CEO in relation to Doctors and Dentists in Difficulty.
Dr Wright Previous Medical Director	7	Dr Wright provided me with the history of the development of the Medical Director's Office and the development of reports to Trust Board, Senior



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		Management Team, and CEO in relation to Doctors and Dentists in Difficulty.

2.3 Until 1st April 2007, there were 4 separate Trusts covering what now makes up the Southern HSC Trust. These were: Craigavon Area Hospital Group Trust; Newry and Mourne Trust; Armagh and Dungannon Trust; and Armagh Community HSS Trust. Each Trust had a Medical Director and each of these persons is, I understand, now retired. In the circumstances, I am fully reliant on information provided by others who were involved in, or have some awareness of, relevant events in these predecessor Trusts. In this regard, I am told by Ms Vivienne Toal that Myrtle Richardson (retired) was Director of HR in Craigavon Area Hospital Group Trust and is likely to have had greatest knowledge at the time of what occurred. I understand that Urology Services were part of the Craigavon Area Hospital Group Trust under legacy arrangements. Records from that time are not available; I understand that, when an approach was made to the Department of Health by Mrs Zoe Parks, they explained that they have not retained copies on their electronic systems. *Please see:*

- 1. *E re Notifications from Trusts re Implementation of MHPS*
- 2. *Handling Concerns about the Performance of Healthcare Professionals*

3. Provide a copy of any forerunner (or any earlier iteration) of the Trust's internal policy, "*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance*" dated 23 September 2010 ("the 2010 Guidelines").

3.1 I am not aware of, nor has the Trust been able to locate, any earlier version of this specific document other than a draft version from September 2010. I have attached this as well as other documents that would have existed at the time. *Please see:*



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- *2. Handling Concerns about the Performance of Healthcare Professionals*
- *3. NCAS How to Conduct a Performance Investigation 2010*
- *4. NCAS Handling Concerns Good Practice 2006*
- *5. 20051100 - Ref 60 MAINTAINING HIGH PROFESSIONAL STANDARDS FRAMEWORK*
- *6. 20100923 Ref 2r - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS)*
- *8. NIMDTA POLICY RE DRS IN DIFFICULTY 2008*

4. Provide a copy of the document referred to at paragraph 1.8 of the 2010 Guidelines at Annex D, namely “SHSCT Clinical Manager’s MHPS Toolkit”.

4.1 The document entitled “SHSCT Clinical Manager’s MHPS Toolkit” (and referred to at paragraph 1.8 of the 2010 Guidelines) was, I understand, a document that was proposed at that time but that had not been developed. I am informed by Mrs Zoe Parks, Head of Medical HR, that the intention behind this was to add some standard template letters at the end of the Trust Guidelines of 2010 that could be used by clinical managers. However, I understand that no toolkit was actually developed. Instead, HROD provided managers with template letters as required.

4.2 I note that the (inaccurate) toolkit reference was not repeated in the 2017 version of the MHPS Guidelines. Please see:

- *Page 3 of attachment 6. 20100923 Ref 2r - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS)*
- *10. 20171000 Ref 2i - SHSCT Guidelines for Handling Concerns about Doctors*



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5. Provide copies of all consultations, reviews and documentation outlining the decision-making process which led to the amendment and updating of the 2010 Guidelines and the production and implementation of the Trust's internal policy, *"Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance"* dated October 2017 ("the 2017 Guidelines").

5.1 Given that I was not employed in the Trust until 1st December 2018, I was not involved in, nor aware of, the development of these documents. As such, I have relied on information from others to inform my response to this question, in particular, Mrs Vivienne Toal, Director of HROD, and Mrs Zoe Parks, Head of Medical HR.

5.2 The account set out at paragraphs 5.3 to 5.18 below, and the email attachments referred to below, was provided to me by Mrs Toal.

5.3 As referenced above, the Trust Guidelines for Handling Concerns About Doctors' and Dentists' Performance were published on 23rd September 2010.

5.4 I understand that, on 4th August 2010, Kieran Donaghy, then Director for HR, emailed Mrs Vivienne Toal and this email was subsequently forwarded to Siobhan Hynds on 9th August 2010. This email requested a review of two draft documents developed by two separate members of staff containing guidance on how to deal with managing poor clinical performance and underperforming doctors. I understand that Mrs. Anne Brennan, Senior Manager in the Medical Director's Office, developed the first document and Mrs. Debbie Burns, Assistant Director of Performance Improvement in the Performance and Reform Directorate, developed the second document.

5.5 In the email dated 4th August 2010 Mr. Donaghy outlined that he had met with 'Mairead' (whom I assume was Mrs Mairead McAlinden, then Chief Executive) and 'Paddy' (whom I assume was Dr. Patrick Loughran, then Medical Director) to agree Mrs Burns' submission including changes. I understand at this point that Mr. Donaghy asked Mrs. Toal and Mrs.



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Hynds for their comments. Mrs. Toal informs me that she, Mrs. Brennan, and Mrs. Hynds met to review the contents of the two sets of draught guidance on 11th August 2010.

Please see:

- 11. 2010.08.09 a Email VToal to SHynds re Guidelines for Managing MHPS
- 12. 2010.08.09 d A Brennan doc Att to Email from A Brennan to Dr P Loughran re handling concern
- 13. 2010.08.09 b D Burns doc Att to VToal's email to SHynds re Guidelines for Managing MHPS
- 14. 2010.08.11 Email from A Brennan to V Toal_S Hynds re meeting that date with att

5.6 Mrs. Toal advises me that Mrs. Brennan sent a copy of the draft guidelines (*please see 15. 2010.08.11 Att to Email from A Brennan to V Toal_S Hynds re meeting that date*). Mrs. Toal went on to state, when I discussed this with her, that she believes that, as a result of this meeting of 11th August 2010, there was to be a further draft of the Trust Guidance developed and she states that she has an email 2010 0814 from her to Siobhan Hynds re image PS Guidance to be checked with Kieran Donaghy and referred to with an attached draft procedure document sent to Siobhan Hynds on 14th August 2010. Please see: -

- 16. 2010.08.14 a Email from V Toal to S Hynds re MHPS guidance to check with K Donaghy with att
- 17. 2010.08.14 b Att doc to Email from VToal to SHynds re MHPS guidance to check with K Donaghy

5.7 Mrs Toal advises that, on 16th September 2010, Mr. Donaghy emailed the Senior Management Team with a version of the Trust Guidelines which had been agreed the previous day at SMT meeting and that these would form the basis of Training with NCAS on 24th September 2010 (*please see 18. 2010.09.16 a Email from KDonaghy to SMT re MHPS Trust guidelines with att and 19. 2010.09.16 b Att to Email from KDonaghy to SMT re MHPS*



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Trust Guidelines). I refer in this regard to the minutes from the meeting in September 2010 (please see 20. 2010.09.08 SMT Notes and 21. 2010.09.15 SMT Notes)

5.8 Mrs. Toal further made me aware that, also on 16th September 2010, Dr Loughran, Medical Director, emailed Dr Fitzpatrick in NCAS in relation to leading a medical leadership network on 24th September 2010. He had attached an agenda for the training session and a copy of the Trust Guidelines agreed at Senior Management Team meeting the day before. Please see 22. 2010.09.16 a Email from Dr Loughran to Dr C Fitzpatrick re NCAS session at ML Network 24.9 with atts, 23. 2010.09.16 b Att agenda to Email from Dr Loughran to Dr C Fitzpatrick and 24. 2010.09.16 c Att Trust Guidance to Email from Dr Loughran to Dr C Fitzpatrick.

5.9 Mrs. Toal further advises that Mrs Hynds sought comments on draft guidance from the Trust's Associate Medical Directors. She describes an email sent by Mrs. Hynds on 23rd September 2010 with a further amended version of the Trust Guidelines attached and a request to Mrs. Brennan to check that amendments were reflective of the AMD comments before the final document was distributed (please see 25. 2010.09.23 b Att Trust Guidelines 23.9.2010 attached to email from S Hynds to A Brennan AMD comments). Mrs. Toal states that she and Mrs. Hynds presented to Senior Medical Managers and the Senior Management Team Directors on 24th September 2010 (please see 26. 2010.09.23 a Email from S HYnds to VToal re slides for ML Network next day with att, 27. 2010.09.23 b Slides att to Email from S Hynds to V Toal re ML Network next day, 28. 2010.09.23 c Email from V Toal to S Hynds with slides for ML Network next day with att, 29. 2010.09.23 d Slides att to Email from V Toal to S Hynds _ ML Network next day, 30. 2010.09.24 e EMail from V Toal to SHynds re ML Network slides with att, 31. 2010.09.24 f Slides att to Email from VToal to SHynds re ML Network presentation).

5.10 Mrs. Toal recalls that the Southern Trust Guidelines 2010 were developed to support the implementation of Maintaining High Professional Standards in the modern NHS (2005) and the 2010 NCAS Guide (please see 32. 2010.01.01 NCAS publication_ How-to-conduct-a-local-investigation and 5. 20051100 - Ref 60 MAINTAINING HIGH PROFESSIONAL



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STANDARDS FRAMEWORK). I understand that legal advice was not sought in relation to this and that this was unusual.

5.11 Mrs. Toal states that she and Mrs. Hynds started to review the 2010 Trust Guidelines in 2017 following their involvement with the case involving Mr. O'Brien. She states that they had particular difficulties at the early stages of the process of the oversight group and, in particular, confusion about roles and responsibilities in the management of concerns. This is reflected in emails in (*please see 33. 2017.02.21 Email SHynds to AMurphy request to set up meeting to review MHPS guidance and 34. 2017.02.22 Email from A Murphy confirming date of meeting to review MHPS guidance*).

5.12 Attachments 35. 2017.04.05 a Email from Z Parks to VToal, SHynds, HWalker with draft changes to Trust Guidelines with att, 36. 2017.04.05 b Att 2010 Trust Guidelines to Email from Z Parks to VToal_SHynds_HWalker and 37. 2017.04.05 c Att draft 2017 Trust Guidelines to Email from Z Parks to VToal_SHynds_H Walker outline that Mrs. Parks was involved in actively revising draft versions of the Trust Guidelines following a meeting on 5th April 2017 which in turn were sent by Mrs. Parks on 6th June 2017. This had been done on 16th June 2017. DLS comments are included in 38. 2022.06.06 Att to Z Parks email_Trust Guidelines 2017 tracked with DLS comments on 4.8.2017 and formed part of the draft Guidelines.

5.13 These in turn were shared with Associate Medical Directors on 24th November 2017 (*please see 39. 2022.06.06 Att email to Email Z Parks confirming AMD views sought on revised 2017 Guidelines_24.11.2017*) and included on the Joint HR Directorate in the Medical Directorate Meeting on 1st December 2017 referenced in notes (*please see 40. 20171201 Notes of Medical _HR Directorate meeting*)

5.14 These were shared as final Guidelines to the Local Negotiating Committee (LNC) of the BMA on 2nd March 2018 for information (*please see 41. 2022.06.06 Email from Z Parks confirming revised Guidelines shared with LNC on 2nd March 2018*).



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5.15 I am informed by Mrs Zoe Parks and believe that the purpose of the revised 2017 Guidelines was understood to have been as follows:

- a. To provide more practical guidance to managers on how to manage concerns locally/informally (as this is not detailed in MHPS); and
- b. To ensure that, when formal concerns were established, it is important MHPS is followed.

5.16 She and Mrs Toal describe that the learning from cases in the interim time frame (i.e., between 2010 and 2017) identified that it was considered important to ensure there was no confusion around the fact that decisions are taken by Case Managers and, whilst the Oversight Directors can be consulted, they are not responsible for taking decisions in MHPS cases.

5.17 The revised Guidelines therefore ensured the references to the Oversight group reflected this. At the time, Trust HR staff consulted with DLS around learning from cases and sought their views for updating Trust guidance. On foot of the current Public Inquiry, the Trust is now updating its Guidance to a 2022 version which will hopefully be available in the near future.

5.18 My reflection in relation to MHPS is that this process was enormously time consuming, elongated and demanding. Interestingly, the Guidance does not consider what occurs if the Case Manager ignores the advice of the Oversight Group and whether the Medical Director or Chief Executive hold accountability in this scenario and can intervene. The Guidance is complex and can be confusing in determining whether concerns are about capability or conduct. They are time intensive, requiring the input of senior Trust staff and are set around largely unachievable deadlines. The right to legal representation, the availability of senior (and already over-committed) clinical and administrative staff, and the tendency of Mr O'Brien to rehearse every



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argument and not address the key concerns, greatly elongated this process.

Please see:

- 5. 20051100 - Ref 60 MAINTAINING HIGH PROFESSIONAL STANDARDS FRAMEWORK

6. Provide a copy of the Trust's internal appeal process relating to clinical performance cases as required by Section IV paragraph 20 of MHPS.

6.1 This is set out in Appendix 4 within the Trust Guidelines of 2010 and is depicted as a flowchart entitled "Appeal Procedures in Clinical Performance Cases". The same applies in the later version of this document in 2017.

6.2 I am informed by Mrs Vivienne Toal and believe that this is the only place where this process is set out – i.e., it is not documented separately in employment contracts or the Medical and Dental Terms and Conditions of Service.

Attached is the MHPS Framework for NI (*please see 5. 20051100 - Ref 60 MAINTAINING HIGH PROFESSIONAL STANDARDS FRAMEWORK*) and the MHPS Framework GB (*please see 43. MHPS Framework GB*). Please also see:

- 10. 20171000 Ref 2i - SHSCT Guidelines for Handling Concerns about Doctors
- 44. RQIA PROFESSIONAL GOVERNANCE REVIEW 2017

7. With regard to Section I paragraph 8 of MHPS:

I. Outline the manner and the processes by which all concerns are to be registered with the Chief Executive.

7.1 Previously, I understand that there has been no formally documented process for reporting informal and formal concerns about doctors to the Chief Executive. I also understand that the process of reporting to the Chief



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Executive may not have been undertaken consistently in the past – i.e., not *all* concerns may have been reported to him or her (in particular, there may have been a distinction between those that had reached a formal MHPS stage and those that had not – see further para 7.4 below). I am now rectifying this and all concerns will now be shared with me as Chief Executive. In conjunction with HROD and staff working in the Medical Director's Office (until the arrival of the recently externally appointed Medical Director in late Autumn), I hope to have this fully in place by the end of September.

7.2 I do not have access to all of the informal communications that occurred in the past, but I can say that any significant concerns that I had as Medical Director about doctors I raised either through the one to one meetings with the Chief Executive, Mr Devlin, or informally with him. The Chief Executive's Office is directly opposite the Medical Director's Office which is, in turn, beside the Director of HROD Office on the Senior Management Team landing in Trust Headquarters on the Craigavon Hospital Site. *Please see attachments 45 to 109.*

7.3 Alongside this, through the responsibility delegated to the Medical Director, all concerns were registered for discussion via the Trust oversight process in place and those about whom there were concerns were (as mentioned in the previous paragraph) discussed with the Chief Executive and, in the case of Mr O'Brien, with Trust Board in the confidential section of its meetings.

7.4 The MHPS Framework (in particular, Section I, page 6, para 8), perhaps unusually, does not describe the roles and responsibilities of the Medical Director other than when s/he is the Case Manager and does not explicitly mention him/her informing the CEO. I understand that, prior to my arrival, only those going through formal aspects of MHPS and who therefore



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required a “designated Board member”, may have been communicated to the CEO and Chair’s offices through a request from Medical HR . On speaking to Dr Wright, I understand that prior to my arrival Mr O’Brien’s case was discussed on a number of occasions during 1:1 meetings with the Chief Executive. *Please see:*

- *Attachments 45 – 109 = CX 1-1 Meetings*
- *Attachments 110 – 114 = Oversight meetings*
- *Attachments 115 – 118 = Trust Board Confidential Meetings*

7.5 As a consequence of reviewing the 2017 Guidance and addressing this Section 21 Notice, the Trust now is in the process of developing updates to Trust Board in relation to MHPS on a regular basis. The Template for this will be shared with the Inquiry when available. *Please see 118. Trust Board Cover Sheet Urology 23 June MO’K.*

7.6 The Trust is also now in the process of developing a formal reporting Template for all Informal and Formal MHPS cases which shall be sent automatically by the Medical HR Team to the Chief Executive and copied to the Medical Director. This will now form part of the monthly one to one meetings between the CEO and MD and will form part of a quarterly report to SMT and biannually to Trust Board.

7.7 In addition to this, as part of the one to one template being developed for implementation with the recently appointed Medical Director, there will be a standing agenda item on this that all Doctors about whom there are concerns will be reviewed monthly.

- II. Provide all records of this registration with regard to the concerns which arose in connection with Mr. Aidan O’Brien.**



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Please see:

- *Attachments 49 – 109 = CX 1-1 Meetings*
- *Attachments 110 – 114 = Oversight meetings*
- *Attachments 115 – 118 = Trust Board Confidential Meetings*

7.8 I understand, from a discussion with Dr Wright by telephone on the 20th August 2022, that Mr O'Brien was first discussed between Dr Wright as Medical Director and Mr Rice as acting Chief Executive between Christmas 2016 and New Year 2017 in the context of MHPS and the consideration of exclusion. This communication was verbal and not written. I am not aware of written documentation in relation to this other than the 2017 Action Plan which was shared with the Chief Executive.

7.9 Under Dr Khan's tenure as Acting Medical Director, the MHPS report provided as Case Manager was shared with Mr Devlin in September 2018 and I believe from Mr Devlin, that there were formal and informal discussions with Dr Khan in his 1:1 meetings with Mr Devlin.

7.10 I recall that, when I spoke to Mr Devlin CEO on 11th January 2019 after a discussion with Mrs Brownlee (Chair of the Trust), he described that he was made aware by Dr Khan as Acting Medical Director and Case Manager for Mr O'Brien's MHPS case, of concerns in September 2018 requiring the involvement of the HROD and the GMC, which had come to light through SAls. In turn I am informed by Mr Simon Gibson that Mr Devlin spoke to Mrs Gishkori in relation to this thereafter in relation to oversight of the monitoring of the 2017 Action Plan. I am not clear as to when this occurred.

7.11 After being made aware through the email that Mr Haynes shared with me that was sent by Mr O'Brien on the 7th June 2020 that there were



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discrepancies in the patient waiting and surgical lists, and the resulting realisation that there were patients hidden to the system and under the care of Mr O'Brien, I spoke to Mr Devlin in his office.

7.12 From memory, I know that I wanted to make him aware that I had concerns that there were patients who had not been referred for other investigations and treatments by Mr O'Brien. I explained that the staff from the Urology Division were exploring and quantifying immediate patient safety concerns. In discussions with Mr Haynes and Martina Corrigan, we had asked that, as he worked towards retirement, that Mr O'Brien dealt with the administration of patients on his existing case load rather than new patients. I also updated Mr Devlin on my discussions with the GMC and on the Early Alert in relation to this that was being formulated and sent to the DoH.

III. Please confirm whether concerns regarding Mr. Aidan O'Brien were brought to the attention of the Chief Executive during the period March – December 2016. If so, please provide all relevant records with regard to same.

7.13 This predates my tenure in the Southern HSC Trust.

7.14 Having spoken to Dr Wright, he does not believe that concerns in relation to Mr O'Brien were shared with the Chief Executive in the 9 months prior to December 2016. I understand that the Chief Executive in January 2016 was Paula Clarke when the matters of concern were raised with Richard Wright by Heather Trouton / Eamon Mackle. Paula was Chief Executive until March 2016, when Kieran Donaghy took over for a very short period. The letter to Mr O'Brien regarding the concerns was, I believe, issued on 23rd March 2016. It has proven difficult to find out what, if any, concerns were registered with the Chief Executive at that time, perhaps due to the change in personnel in that period.

7.15 To help me in answering this question, I discussed the issue with Mrs Toal, who I believed might have some relevant knowledge as she was in post at the time. Mrs. Toal



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explained to me that Mr. O'Brien first came to her attention when she was approached by Dr Wright, Medical Director, in either late August or early September 2016. She states that, at that point, there was mention of concerns about Mr. O'Brien's administrative practices earlier in the year. She states that Dr Wright believed that those issues had not been fully resolved and he had ongoing concerns about Mr. O'Brien's practice. She recalls that the need to inform the Chief Executive, by that stage Mr. Francis Rice, was discussed at that time.

7.16 I understand that Mr. Simon Gibson forwarded a screening report on Mr. O'Brien to Dr Wright on 5th September 2016 to ask, in addition, if an Oversight Meeting should be convened. This email in turn was forwarded to Mrs. Toal, *(please see 118a. 20160912 Email Screening report and 118b. 20160905 Email Screening report - attachment)* for her awareness and input before the Oversight Meeting. She states that this was in keeping with the Trust 2010 Guidelines.

7.17 Mrs. Toal advises that Mr. Gibson contacted her to state that a meeting of the Oversight Group would be needed the following day and this was duly held on 22nd December 2016 and a decision made that, under the terms of Maintaining High Professional Standards, a formal investigation would proceed in relation to Mr. O'Brien.

7.18 When I spoke to Dr Wright on the 20th August 2022, he also recalled that he had a discussion with Mr Rice between Christmas 2016 and New Year 2017, following the decision at the Oversight Group, to advise him as Chief Executive that Mr O'Brien should be restricted from practice, which duly resulted in his being excluded from practice for a month from 30th December 2016 until 27th January 2017. I am not clear from what is available to me currently if Mr Rice was aware of any other communications about Mr O'Brien prior to this point.

8. With regard to Section I paragraph 29 of MHPS;



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I. Outline the systems within the Trust which established the clear audit route for initiating and tracking the progress, cost and resulting action with regard to an investigation under Section I of MHPS.

II. Provide evidence of what steps the Trust undertook to audit the investigation conducted in relation to Mr. Aidan O'Brien under Section I of MHPS, with particular reference to the progress of the investigation, the cost and resulting action.

(I) Outline the systems within the Trust which established the clear audit route for initiating and tracking the progress, cost and resulting action with regard to an investigation under Section I of MHPS.

8.1 There has, to the best of my knowledge and understanding, been no formalised audit process for initiating and tracking progress, cost and resulting action with regards to an investigation under Section I of MHPS.

8.2 The system that previously kept and continues to keep, an audit trail, tracking progress on cases, is the Trust Oversight Group.

8.3 All formal cases under MHPS also have a Non-Executive Director aligned, as per MHPS, one of whose duties is to oversee the case to ensure momentum is maintained (see MHPS Section I, page 6, para 8, 2nd bullet).

8.4 HROD – MDO meetings recorded updates on the progress of these cases. This was brought together into a formal structure in the course of 2019, realised through the establishment of the Doctors and Dentists' Oversight Group in May 2020 on Zoom and monthly thereafter, following a developmental meeting with Northern Trust in November 2019. The implementation was delayed significantly because of the impact of the Covid 19 Pandemic and the availability of key staff to attend meetings.

8.5 The current process tracks initiation, progress and resulting actions of the MHPS process but does not currently track costs as most of the work on this is carried out in house and, since the review of Medical Leadership structures, forms part of the governance responsibilities of senior medical leaders and clinical managers in the Trust.



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(II) Provide evidence of what steps the Trust undertook to audit the investigation conducted in relation to Mr. Aidan O'Brien under Section I of MHPS, with particular reference to the progress of the investigation, the cost and resulting action.

8.6 I do not believe that this process has been adequately audited as yet. My impression is that this process relied on a stretched HROD resource and practising clinicians, namely Dr Khan and Dr Chada, and their meetings with Mr O'Brien and other clinicians and the challenges of doing this with a number of witnesses because of clinical commitments. There is a sense as well that Mr O'Brien at times dictated the pace of the process, for example, when he prioritised other commitments such as appraisal over attending meetings in relation to MHPS. My impression is that the elongated timescale was not as robustly challenged as was required in this case.

8.7 I am informed by Mrs Toal that, after the Case Determination on the 28th September 2018, and a meeting with Mr O'Brien on the 1st October 2018, HROD- MDO moved to put a Conduct Panel in place. This required accessing time in the busy diaries of 2 of the operational directors and others. DLS at this point advised that this process should be investigated as one of Professional Misconduct and an independent representative was sought. The Belfast Trust was approached and suggested Mr Chris Hagan, Consultant Urologist, though, in retrospect, he had worked with Mr O'Brien in the past within and outside the Southern HSC Trust. This further complicated the setting up of a Professional Misconduct Panel and delayed time scales. This process was then paused when Mr O'Brien raised a Grievance against the Trust in relation to this process.

8.8 Throughout the period before and after the Case Determination, Mr O'Brien was being monitored on the February 2017 Action Plan, albeit that through discrepancies recognized by Mrs Corrigan on the 16th September 2019 (*please see attachments 119 – 125*) it was then identified that the monitoring process was flawed, and then later through the discrepancies noted by Mr Haynes following an email from Mr O'Brien on the 7th June 2020 (*please see attachments 126, 126a - i*).



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8.9 The conclusions from the MHPS Framework investigation (*please see 127. 20180928 Email Case Manager Determination AO'B FINAL 280918 attachment*) in relation to Mr O'Brien included a Conduct Panel, a formal action plan (through which, inter alia, Mr O'Brien's administrative processes might be monitored), and a review of relevant Trust administrative processes.

8.10 Unfortunately, it was not identified from the Case Manager's Determination who was to lead and have oversight of the implementation of the recommendations from his report.

8.11 The review that was to be carried out as part of the outworkings of MHPS was divided into an Administration Review which was completed by Anita Carroll in 2020 and a Managerial Review.

8.13 A Managerial Review which was undertaken by the Trust over the course of the past year and is being enacted through the Structural Review of the Trust and roles and responsibilities of Senior Medical Staff and Senior non – clinical administrative staff. During that time all of the Divisional Medical Director and Clinical Director posts have been strengthened in relation to governance and all of these posts have been reappointed.

8.14 In addition to this, since being appointed as Chief Executive on 1st May 2022, I have begun the process of appointing a Medical Director (appointed and due to start in October), Director of Performance and Reform (no suitable applicants to date so an interim is in place), 2 Interim Directors to replace the recently retired Director of Acute Services, Mrs McClements (substantive posts have been advertised and will be appointed in September), and a Director of Adult Community Care (advertised and will be appointed in September), a Director of Social Work (to be appointed in October/ November) and a Director of Children's Services (to be appointed in October/ November).

8.15 As a result of these appointments, I am introducing a stronger focus on Collective Leadership and on roles and responsibilities in relation to clinical and social care governance



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and more explicit lines of reporting and accountability across medical and non-medical managers.

8.16 Underpinning this has been the outworkings of the Champion Review which I commissioned through the Chief Executive in 2019, the action plan of which is being worked through and implemented sequentially. This process is the focus for the Trust Board workshop externally facilitated by the Leadership Centre on the 26th August 2020 to quality assure processes to date and ensure bed to Board accountability in relation to patient care.

8.17 In a letter to the Trust in July 2022, Mr Peter May, Permanent Secretary DoH, has asked RQIA to undertake a Quality Assurance of Governance Processes in Urology in the Southern HSC Trust.

8.18 In addition to this, the Trust embarked on a review of structures earlier in the year and is now in the process of implementing these changes which aim to improve governance processes. *Please see attachments 128 to 138.*

Training with regard to MHPS

9. With regard to Section VI paragraph 1 of MHPS, outline the training, guidance or support provided by the Trust for the handling of concerns and implementation of the MHPS Framework to those with specific roles under MHPS and the 2010 and 2017 Guidelines. Your answer should address the training provided to;

- I. Clinical Managers**
- II. Case Managers**
- III. Case Investigators**
- IV. Chief Executives**
- V. Designated Board Members**
- VI. HR Staff**
- VII. Service Directors and Assistant Directors.**



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9.1 I have attempted to address these issues in my answer to Q10 below.

10 Outline the training, guidance or support, if any, which was provided by the Trust to each of the following individuals in relation to the handling of concerns and the implementation of the MHPS Framework in respect of Mr. Aidan O'Brien:

- I. **Mr. O'Brien's clinical managers at all levels within the organisation including Mr. Mackle, Dr McAllister, Mr. Haynes, Dr Wright and any other person who filled the role of clinical manager for Mr. O'Brien**
- II. **Dr Ahmed Khan (Case Manager)**
- III. **Mr. Colin Weir and Dr Neta Chada (Case Investigators)**
- IV. **The Chief Executive in office at all relevant times**
- V. **Mr. John Wilkinson (Designated Board Member)**
- VI. **Ms. Siobhan Hynds and Ms Lynne Hainey (HR Staff)**
- VII. **Ms Esther Gishkori, Mr Ronan Carroll, Ms Vivienne Toal, Mr Simon Gibson, Mr Malcolm Clegg, Ms Tracey Boyce and Ms Anne McVey (Attendees at Oversight Committee meetings)**

10.1 I have attached the available records of training that has been provided to Clinical Managers, Associate Medical Directors, Medical Directors and others over the years (*please see attachments 139 to 145*).

10.2 Training was provided by NCAS/NHS Resolution as this is the recognised training for Case Investigators and Case Managers. In the past, before my tenure as Medical Director, I understand that other training sessions were run through the Medical Director's Office, but do not appear to have been recorded formally.

10.3 As a result of this, HROD and MDO are developing a training plan which is being taken to the September 2022 Trust Board meeting for assurance.



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10.4 On the information available to me, the following training, guidance and support appears to have been provided to the persons mentioned in Q9 and Q10.

10.5

Those with specific roles under MHPS and the Guidelines.		Training dates	Guidance	Support
CLINICAL MANAGERS			Case specific guidance in conjunction with HROD and the Medical Director's Office using Maintaining High Professional Standards 2005 and Guidelines from 2010 and 2017 and through the Outworkings of the Doctors' and Dentists' Oversight Group.	Case specific support in conjunction with HROD and the Medical Director's Office using Maintaining High Professional Standards 2005 and Guidelines from 2010 and 2017 and through the Outworkings of the Doctors' and Dentists' Oversight Group
Mr. Mackle	24 September 2010			
Dr McAllister	24 September 2010			
Dr Wright	I cannot find a training record for the Southern HSC Trust but I recall that Dr Wright and I both attended NCAS training in MHPS while we were AMD colleagues in the Belfast Trust, circa 2014.			
Mr McNaboe	Has not yet undertaken training.			
Dr Khan	7-8th March 2017 and 6 th October 2020.			
Dr O'Kane (me)	10th January 2020 and 6th October 2020.			



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Mr. Haynes	6 th October 2020.		
CASE MANAGERS		As above.	As above.
Dr Ahmed Khan	7-8 th March 2017 and 6 th October 2020.		
CASE INVESTIGATORS		As above.	As above.
Mr. Colin Weir	24 th September 2010.		
Dr Neta Chada	24 th September 2010 and 7-8 th March 2017. I understand that Dr Chada is a highly experienced Case Investigator who has been called on by other Trusts to support their processes.		
CHIEF EXECUTIVES		Through formal and informal discussions, updates and assurances provided by the Medical Director, Operational Director, and Director of HROD	Through formal and informal discussions, updates and assurances provided by the Medical Director, Operational Director. and
Mrs Mairead McAlinden	No training recorded.		
Mrs Paula Clarke	No training recorded.		



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Mr Kieran Donaghy	No training recorded.		Director of HROD
Mr France Rice	No training recorded.		
Mr Shane Devlin	No training recorded.		
TRUST BOARD MEMBERS	Board members' training	Through HROD when performing the role of designated NED for formalised cases.	Through HROD when performing the role of designated NED for formalised cases.
John Wilkinson	November 2021		
HR STAFF	Through training and from regular and ongoing consultation with DLS, NHS Resolutions and GMC .	From consultation with DLS, NHS Resolutions and GMC.	From consultation with DLS, NHS Resolutions and GMC.
Ms Vivienne Toal	Ms Toal advises me that she has not been formally trained in MHPS but she and Mrs Hynds were involved in training a range of directors and senior		



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	clinicians on 24 th September 2010 on the Trust 2010 Guidelines along with Dr Colin Fitzpatrick, NCAS.		
Ms. Siobhan Hynds	Trained by June Turkington of DLS along with CDs and AMDs on 7-8 March 2017.		
Lynne Hailey			
SERVICE DIRECTORS & ASSISTANT DIRECTORS	In house training	Through formal and informal discussions, updates and assurances	Through formal and informal discussions, updates and assurances
Ms Esther Gishkori	Not trained.	provided by the Medical Director, Operational Director, and Director of HROD.	provided by the Medical Director, Operational Director, and
Mr Ronan Carroll	Not trained.		
Mr Simon Gibson	August 2016.		
Mr Malcolm Clegg	7-8 March 2017.		



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Ms Tracey Boyce	No records of training.		Director of HROD.
Ms Anne McVey	24 October 2010.		

2010 Guidelines

11. Provide copies of any further guidance which may have been formulated by the Trust and offered to Clinical Managers and/or nominated HR Case Managers regarding the conduct of a “screening process” or “initial verification” process when concerns first arise, other than that referred to at Section 2 of the 2010 Guidelines.

11.1 To be clear, it should be noted that guidance was not confined to section 2 of the 2010 Guidelines but was also contained within appendix 1 of the Guidelines.

11.2 To the best of my knowledge and belief, beyond the above items there has not been any other guidance formulated by the Trust.

11.3 The NCAS 2010 document has a brief section in it in relation to this. Other guidance, which would have been available at the relevant time, were the various documents produced by NHS Resolution (formerly NCAS). These are attached (*please see 3. NCAS How to Conduct a Performance Investigation 2010 and 4. NCAS Handling Concerns Good Practice 2006*).

11.4 The 2010 Guidelines were updated in 2017 and included more guidance on screening initial concerns.

11.5 More updated guidance on judging risk of concerns and the Supporting Doctors in Difficulty HUB have been developed by the SHSCT in recent years. These can be accessed through the Trust website on: <https://view.pagetiger.com/Hub/doctors-in-difficulty-hub>.
Please see:



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146. 20080530 Distribution E Policy re Management of Drs and Dentists in Difficulty

147. Procedure for Handling Concerns re Doctors and Dentists Performance 15 Sept 2010

12. Provide copies of all policies and guidance relating to the establishment, role and functioning of the 'Oversight Group,' as referred to at paragraph 2.5 of the 2010 Guidelines.

12.1 This instigation of this predates my tenure but it has been developed since my arrival, in particular, since it has moved to Zoom from May 2020 onwards.

12.2 The purpose and overview of the Oversight Group was originally outlined within the 2010 Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance. My understanding from this is that the Oversight Group was originally comprised of the Medical Director, Operational Director and Director for HROD. The aim of the Group was to be kept informed of the progress of the MHPS process and that it had a discrete role in certain matters (e.g., in respect of the exclusion of a clinician). I understand that the key purposes were in respect of oversight, quality assurance, and ensuring consistency of approach in the Trust's handling of concerns. I believe that the last of these emanated from the following reference within the NCAS Guide that such a group can be helpful: "The form that screening takes will vary from organisation to organisation. The essential requirement is that a consistent process is followed, with *decisions made by a person or group with appropriate authority. Decisions made should be appropriately recorded and the practitioner kept informed of progress*" (please see 3. NCAS How to Conduct a Performance Investigation 2010).

12.3 Since May 2020 this has taken on a more formalized structure with monthly Oversight meetings by Zoom involving the Medical Director and Responsible Officer, Director HROD, Head of Service for Medical HR, Deputy Medical Director for Workforce and Education, and a scheduled timetable for each of the Divisional Medical Directors and Operational Directors



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to present Doctors and Dentists in difficulty in their Directorate and develop management plans. The information in relation to this is now held by HROD in a readily accessible dashboard.

12.4 Since Mr O'Brien retired from the Southern HSC Trust in July 2020, his case has not been discussed at this Oversight Group as the Trust is no longer his employer and I was no longer his GMC Responsible Officer, this responsibility having passing directly back to the GMC. Please see:

128. TERMS OF REFERENCE DOCTORS AND DENTISTS OVERSIGHT GROUP

148. 20200513 Medical Oversight Action Notes

13. With regard to paragraph 3.3 of the 2010 Guidelines, outline the procedures in place to ensure that the findings of informal and formal stages are recorded and available to appraisers. Further, in answering this question you are also expected to outline any procedures which are or were in place for monitoring or ensuring the consideration and reflection of such findings at appraisal. If such procedures were not in place at the conclusion of the MHPS investigation relating to Mr O'Brien you should say so, and indicate when, if at all, the procedure was introduced.

	Prior to May 2020	May 2020 onwards
Outline the procedures in place to ensure that the findings of informal and formal stages are recorded and available to appraisers.	Such procedures were not in place at this time. Findings of informal and formal cases were, since 2017, discussed at Doctors' and Dentists' Oversight Group (DDOG) meetings which were not always attended by the relevant Associate Medical Director or Director of Service/ Divisional Medical Director/ Director associated with the	Through a review of the Appraisal and Revalidation processes in the Trust, this is now in being developed through an Appraisal and Revalidation Policy. This Policy will explicitly require what is being developed implicitly



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	Doctor and previously were initiated in relation to specific cases as required, rather than formally timetabled with clear roles, responsibilities, and agendas, as has been the case since May 2020. The MHPS Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance of 16th September 2010, in 3.3, describe that findings and recordings from informal or formal stages of MHPS are recorded and made available to the Appraisers by the Clinical or Case Manager. On review of the October 2017 Guidelines, this provision was subsequently dropped. I am unable to ascertain from the correspondence at that time the rationale for this change. On reflection, however, this decoupled the Appraisal and the MHPS process. Of interest, neither version of these Guidelines suggests that concerns should be escalated by the Appraiser to the Clinical Manager outside of the usual requirement that patient safety concerns are communicated. In addition to this, because the system in the past had been that doctors chose their own appraiser from a list of trained appraisers, there was not an automatic read	currently, namely, that, as outlined in the 2010 Guidelines, Formal and Informal concerns are passed to the appraiser by the Case or Clinical Manager and that, if the Appraiser has identified concerns in relation to an Appraisee, these in turn are escalated to the Clinical Manager, all with the full knowledge of the Appraisee. This will be finalised in October 2022.



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	across from Appraiser to Clinical Manager and vice versa. As such, if the Appraiser had concerns they were written into the appraisal but potentially not discussed outside of this or escalated to any manager. There was a strong belief that appraisal was confidential and, unless specific patient safety concerns were raised, could not be discussed outside appraisal. Likewise, if the manager had concerns about the doctor, typically they would have relied on the appraisee to bring these concerns to the appraisal process. There was no checking mechanism in place to ensure this was done. Appraisals were not reviewed by clinical line managers to ascertain if there were areas of concern requiring action plans. When I arrived in the Trust, I reviewed appraisals as part of the Medical Director signoff and brought to the attention of managers any concerns raised. This had the potential to become an unwieldy process and is now being formalized through a review of the Appraisal and Revalidation systems. This document will be forwarded in October when completed. Prior to my arrival, the Revalidation process depended on appraisals. In the course of setting up the Revalidation Oversight	



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	Group, I depended initially on contacting individual Associate Medical Directors to ascertain if they had any concerns outside of any of their doctor's appraisal. On the back of this I developed a checklist and a timetabled meeting, not just with the then Associate Medical Director responsible for each doctor but, as the Divisional Directors were appointed, all of this grouping and the Deputy Medical Directors, to provide robust oversight over the process of each doctor's revalidation. <i>(please see 149. TERMS OF REFERENCE MEDICAL REVALIDATION OVERSIGHT MEETING and 150. Revalidation Oversight Timetable 2022)</i>. As this has progressed it has become more comprehensive. <i>(please see 151. DMD Checklist and 152. AMD REVALIDATION CHECKLIST)</i>.	
Outline any procedures which are or were in place for monitoring or ensuring the consideration and reflection of such findings at appraisal.	If this was raised by the appraisee during Appraisal this was reflected upon in the body of the Appraisal under any of the 4 domains of Good Medical Practice, namely: Knowledge, Skills and Performance; Safety and Quality; Communication, Partnership and Teamwork; and Maintaining Trust. The responsibility then for ensuring that this was in place rested with the Appraisee in bringing the information and the Appraiser	This has been strengthened both through the appraisal and revalidation processes and is being captured in the development of the 2022 Appraisal and Revalidation Policy which, as stated above,



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	in facilitating and reviewing the reflection. The Reflections are part of attached information in the appraisal process and were expected to be attached to the RASP electronic system in place. These in turn then could be reviewed by the Medical Director if necessary. The process has always relied on the Appraisee being open and honest with the Appraiser, supported by information provided by various data sources throughout the Trust, including complaints, clinical activity data, and probity and health statements.	will be forwarded to the Inquiry in October . There is an expectation that Appraisees will bring all significant events to appraisal for discussion and reflection.
If such procedures were not in place at the conclusion of the MHPS investigation relating to Mr O'Brien you should say so, and indicate when, if at all, the procedure was introduced.	These were not in place at that time	



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Please see also see documentation of when Mr O'Brien was discussed at DDOG since January 2019 (*attachments 153 to 172*).

14. With regard to paragraph 3.4 of the 2010 Guidelines, provide copies of any presentation to SMT Governance by the Medical Director and Operational Director concerning the investigation conducted into Mr Aidan O'Brien. Should no presentation have taken place, please outline the reasons why, and provide any document recording those reasons.

14.1 Paragraph 3.4 of the 2010 Guidelines states that "all formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed". This is then described in Appendix 2 of the 2017 Guidelines on page 12 (last box) which states that "Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case has closed".

14.2 In the course of my tenure as Medical Director there has, to the best of my knowledge, been one case formally investigated and managed through to completion and learning and this is due for presentation to SMT in September 2022. I am not aware, nor are others working in the Trust with whom I have explored this issue, of any other cases which have been brought formally to SMT.

14.3 In this regard I have contacted the previous Medical Directors in the Southern Trust, namely, Drs Loughran, Simpson, Wright, and Khan. I have also raised the issue with Mr Gibson, Assistant Director. None can recall this action being undertaken.

14.4 The position therefore appears to be that this process was not followed regarding Mr O'Brien's case. There appears to have been a lack of awareness across previous Medical Directors, HROD staff and Chief Executives that this was required. This has now been rectified.



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15. Provide any further relevant documentation, guidance or evidence with regard to the implementation and effectiveness of MHPS by the Trust generally and, specifically, concerning the investigation conducted into Mr Aidan O'Brien. If the Trust has communicated with any other organization in respect of these matters, such documentation should be provided.

15.1 I believe that this has been dealt with through my responses to Questions 54 and 55 of Section 21 Notice No.29 of 2022.

15.2 I understand, from a discussion with Mrs Toal on the 22nd August 2022, that she and Mrs Zoe Parks have in the past (in approximately 2012 and 2018) provided comments in relation to MHPS to the Department of Health for the purposes of a proposed review but my understanding is that, as yet, no review has been commenced. However, Mrs Toal has advised me that, as Chair of the HR Directors' Group, she spoke with Phil Rodgers, Director of Workforce Policy in the Department of Health, by telephone on 13th June 2022, about the outstanding review of MHPS. At that stage I understand that Mrs Toal may have been working her way through her own Section 21 response. In addition, I understand that Mrs Toal emailed Mr Rogers on the 30th June 2022 and asked that MHPS be an agenda item at the next HR Forum with the Department of Health (*please see 173. 20220630 MHPS - HR Forum*). I further understand that Mr Rodgers agreed to place the issue of a review as an agenda item on the next HR Directors' Forum meeting for discussion. The meeting of the HR Directors' Forum duly took place on 4th July 2022 and I understand that, at the meeting, Mr Phil Rodgers advised that the Department of Health had identified the need to take forward an urgent review of MHPS. He also referred in this meeting to the Neurology Public Inquiry report published on 21st June 2022 having included references to parts of the MHPS Framework requiring review in three of its recommendations. Trusts are now awaiting the establishment of a Department of Health led group to take forward a review of the MHPS Framework.

15.3 Internally, the Trust now recognises the following:



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- a. The need to ensure communication with Trust Board on these matters - An update to Trust Board on MHPS cases is planned for the Confidential Section of Trust Board in September.
- b. The need for training - In addition, an MHPS Training Plan is being submitted to Trust Board in September.
- c. The need for better communication and capture of learning - The Terms of Reference of the Doctors' and Dentists' Oversight Group will be reviewed to ensure that learning is captured, particularly in relation to ensuring that MHPS cases are communicated in a timely fashion to the Chief Executive, SMT Governance meetings, and regularly updated to Trust Board and that there is clear communication in relation to the Appraisal processes.
- d. The need to update guidance - The Trust Guidelines on MHPS will be updated in 2022.

15.6 Documentation regarding all of these developments will be provided as discovery to the Inquiry as they become available.

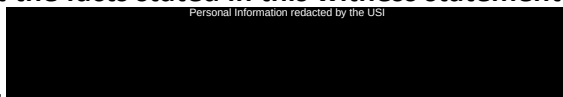
NOTE:

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

Statement of Truth

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

Signed: _____





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Date: 26th September 2022

Section 21 Notice Number 51 of 2022**Witness Statement: Dr O’Kane****Index**

Attachment	Document Name
1	E re Notifications from Trusts re Implementation of MHPS
2	Handling Concerns about the Performance of Healthcare Professionals
3	NCAS How to Conduct a Performance Investigation 2010
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5	20051100 - Ref 60 MAINTAINING HIGH PROFESSIONAL STANDARDS FRAMEWORK
6	20100923 Ref 2r - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS)
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10	20171000 Ref 2i - SHSCT Guidelines for Handling Concerns about Doctors
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13	2010.08.09 b D Burns doc Att to VToal's email to SHynds re Guidelines for Managing MHPS
14	2010.08.11 Email from A Brennan to V Toal_S Hynds re meeting that date with att
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170	20200212
171	20200212_1
172	20200212_2
173	20220630 MHPS - HR Forum

Stinson, Emma M

From: OKane, Maria
Sent: 30 August 2022 16:00
To: Stinson, Emma M
Subject: q1 section 21 : 51 attachment

From: Parks, Zoe <[Personal Information redacted by the USI]>
Sent: 30 August 2022 15:57
To: OKane, Maria <[Personal Information redacted by the USI]>
Subject: FW: Quick Query

From: Parks, Zoe
Sent: 27 July 2022 13:25
To: Toal, Vivienne <[Personal Information redacted by the USI]>
Subject: FW: Quick Query

Just to let you know I spoke to Katherine in the Dept. re the confirmations from NI Trusts around MHPS by 31 January 2006. They were asked something similar by PI and advised that they don't hold copies of these responses from previous Trusts as this was before their new electronic system was introduced. The paper copies have been destroyed in line with records management.

From: Ferguson, Katherine <[Personal Information redacted by the USI]>
Sent: 26 July 2022 09:07
To: Parks, Zoe <[Personal Information redacted by the USI]>
Subject: RE: Quick Query

Hi Zoe,

Tried calling there but got your voicemail, I'm about most of today if you want to give me a buzz, though I've meetings 10-11, 11.30 – 12 and 3.30-4.30#

Best bet is the landline and my mobile signal is rubbish

Thanks

K

Katherine Ferguson
Pay & Employment Unit

tel – [Personal Information redacted by the USI] ext – [Personal Information redacted by the USI]
mobile – [Personal Information redacted by the USI]

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Organ donation law is changing in spring 2023, find out more



From: Parks, Zoe <[Personal Information redacted by the USI]>

Sent: 26 July 2022 08:50

To: Ferguson, Katherine <[Personal Information redacted by the USI]>

Subject: Quick Query

In the context of our Public Enquiry – could you give me a quick ring when you are free. I have a quick question I’m hoping you can help me with.

Many thanks

Zoë

Zoë Parks

Chartered MCIPD

Head of Medical HR

Southern Health & Social Care Trust

Tel: [Personal Information redacted by the USI]

Mob: [Personal Information redacted by the USI]



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

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clinical scientists art therapists
operating department practitioners
prosthetists and orthotists
speech and language therapists
physiotherapists dietitians

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Planning
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Estates
Performance
IM & T
Finance

Partnership Working

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

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

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

Handling Concerns about the Performance of Healthcare Professionals

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

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

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

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

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

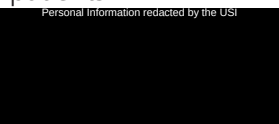
This document is not intended to replace organisations' own policies and procedures. Rather, it outlines key principles and elements for handling performance concerns which should be helpful for managers and for professionals themselves.

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

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

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

Personal Information redacted by the USI



London

1. INTRODUCTION

The aims of this publication and its intended audience

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

The document aims to:

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

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

In this document:

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

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

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

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

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

How the document was developed

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

What is covered

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

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

What is not covered

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

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

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

2. PRINCIPLES FOR HANDLING PERFORMANCE CONCERNS

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

Concerns about performance may relate to:

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

Principle 1 Patient safety must be the primary consideration

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

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

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

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

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

Policies for handling performance concerns should cover:

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

Principle 4 Avoid unnecessary or inappropriate exclusion of practitioners

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

Principle 5 Separate investigation from decision-making

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

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

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

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

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

Principle 8 Good human resources practice will help prevent performance problems

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

Good human resource practices include:

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

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

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

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

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

Principle 11 Commitment to equality and diversity

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

3. GOOD PRACTICE IN HANDLING CONCERNS

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

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

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

Receiving information about a concern

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

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

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

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

Considering the risk to patient safety

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

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

VIGNETTE

The importance of taking action early

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

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

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

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

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

Informing the practitioner

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

Support for the practitioner

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

Dealing with a concern informally

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

GOOD PRACTICE

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

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

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

Dealing with a concern formally

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

Gathering information – undertaking an investigation

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

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

Deciding what to do

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

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

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

Understanding contributory factors

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

THINK ABOUT:

The individual's health and other factors

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

Knowledge, skills and behaviour

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

The job

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

The work environment

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

Interventions and remedial action

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

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

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

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

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

VIGNETTE

Planned recovery and support for a pharmacist

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

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

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

VIGNETTE

Addressing a concern

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

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

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

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

VIGNETTE

Working beyond capacity

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

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

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

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

VIGNETTE

Informing the regulatory body

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

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

Review and supplementary action

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

Passing information

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

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

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

Aftermath and rehabilitation

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

GOOD PRACTICE

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

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

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

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

4. OTHER ISSUES TO CONSIDER

Role of the regulatory bodies

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

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

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

Questions to ask in considering referral to the regulatory body:

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

GOOD PRACTICE

Training to report a concern

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

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

Whistleblowing: raising a concern about a colleague's performance

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

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

Handling difficulties in teams

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

VIGNETTE

Adjusting teamwork to take into account individual needs

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

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

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

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

Using locums, agency and bank staff

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

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

Managing locum services

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

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

Equality and diversity

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

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

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

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

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

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

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

Conclusion

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

ANNEX 1

MEMBERSHIP OF THE WORKING GROUP

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Leicester, Northampton and Rutland
Strategic Health Authority

Dr Janine Brooks

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National Clinical Assessment Service
National Patient Safety Agency

Ms Barbara Clague

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Professional Officer for Policy and Practice
Department of Health

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Adviser to CMO (England), HR Adviser to
NCAS
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Ms Rachel Tripp

Policy Manager
Health Professions Council

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Royal College of Nursing

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

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

ANNEX 2

RELEVANT ORGANISATIONS

ACAS

ACAS provides a variety of sources of information and resources about producing disciplinary and grievance procedures. Resources include seven free e-learning programmes to help individuals and businesses on topics such as discipline and grievance, information and consultation. The site is accessible to both employers and employees.

Contact ACAS at:

Telephone helpline: 08457 474747

Website: www.acas.org.uk

British Dental Association

The British Dental Association (BDA) is the professional association and trade union for dentists in the UK. The BDA develops policies to represent dentists working in every sphere from general practice, through community and hospital settings, to universities and the armed forces.

Contact the BDA at:

Telephone: 020 7935 0875

Email: enquiries@bda.org

Website: www.bda-dentistry.org

British Medical Association

The British Medical Association (BMA) represents doctors from all branches of medicine all over the UK. It is a voluntary association, provides services for members, is an independent trade union and a scientific and educational body.

Contact the BMA at:

Telephone: 020 7387 4499

Website: www.bma.org.uk

The Centre for the Advancement of Interprofessional Education

The Centre for the Advancement of Interprofessional Education (CAIPE) promotes and develops collaboration between practitioners and organisations across the public services and is a resource for interprofessional education. It offers access to research and information and examples of good practice, conferences and it responds to policy documents.

Contact CAIPE at:

Telephone: 020 7554 8539

Email: admin@caipe.org.uk

Website: www.caipe.org.uk

Council for Healthcare Regulatory Excellence

The Council for Healthcare Regulatory Excellence (CHRE) is a statutory overarching body, covering all of the United Kingdom and separate from government, established in 2003. It promotes best practice and consistency in the regulation of healthcare professionals.

Contact the CHRE at:

Telephone: 020 7389 8030

Email: info@chre.org.uk

Website: www.chre.org.uk

General Chiropractic Council

The General Chiropractic Council (GCC) is a UK-wide statutory body with regulatory powers. Its duties are to regulate chiropractors, set standards for education, conduct and practice, and to develop and promote the profession of chiropractic.

Contact the GCC at:

Telephone: 020 7713 5155

Email: enquiries@gcc-uk.org

Website: www.gcc-uk.org

General Dental Council

The General Dental Council (GDC) is the organisation which regulates dental professionals in the UK.

Contact the GDC at:

Telephone: 020 7887 3800

Email: communications@gdc-uk.org

Website: www.gdc-uk.org

General Medical Council

The General Medical Council (GMC) registers doctors to practise medicine in the UK. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

Contact the GMC at:

Telephone: 0845 357 8001

Email: gmc@gmc-uk.org

Website: www.gmc-uk.org

General Osteopathic Council

The General Osteopathic Council (GOsC) regulates the profession of osteopathy, sets standards of osteopathic practice and conduct, assures the quality of education, ensures continuing professional education and helps patients with complaints about an osteopath.

Contact the GOsC at:

Telephone: 020 7357 6655

Email: info@osteopathy.org.uk

Website: www.osteopathy.org.uk

General Optical Council

The General Optical Council (GOC) is the statutory body which regulates dispensing opticians and optometrists and those bodies conducting business as optometrists or dispensing opticians. The GOC's main aims are to protect the public and promote high standards of professional conduct and education among opticians.

Contact the GOC at:

Telephone: 020 7580 3898

Email at: goc@optical.org

Website: www.optical.org

Health Professions Council

The Health Professions Council (HPC) regulates 13 professions: art therapists, biomedical scientists, chiropractors and podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, and speech and language therapists. The HPC sets standards covering health professionals' education and training, behaviour, professional skills, and their health.

Contact the HPC at:

Telephone: 020 7582 0866

Email: policy@hcp-uk.org

Website: www.hpc-uk.org

Independent Healthcare Advisory Services

The Independent Healthcare Advisory Services (IHAS) is a subscription-based service for independent healthcare providers which manages the independent sector complaints adjudication service and oversees the effective resolution of complaints.

Contact the IHAS at:

Telephone: 020 7379 7721

Email: [Personal information redacted by USI]

Website: www.independenthealthcare.org.uk

National Clinical Assessment Service

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

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

Contact the NCAS at:

Telephone: 020 7084 3850

Email: ncas@ncas.npsa.nhs.uk

Website: www.ncas.npsa.nhs.uk

National Patient Safety Agency

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

NPSA produces a range of publications including:

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

Contact the NPSA at:

Telephone: 020 7927 9500

Email: enquiries@npsa.nhs.uk

Website: www.npsa.nhs.uk

NHS Employers

NHS Employers is the employers' organisation for the NHS in England giving employers throughout the NHS an independent voice on workforce and employment matters. NHS Employers offers a range of events, publications and information.

Contact NHS Employers at:

Telephone: 0113 306 3000

Email: enquiries@nhsemployers.org

Website: www.nhsemployers.org

Nursing and Midwifery Council

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

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

Contact the NMC at:

Telephone: 020 7637 7181

Email: communications@nmc-uk.org

Website: www.nmc-uk.org

Royal College of Midwives

The Royal College of Midwives (RCM) is a trade union and professional organisation run by midwives for midwives. It provides leadership in midwifery, education and representation for members.

Contact the RCM at:

Telephone: 020 7312 3535

Email: info@rcm.org.uk

Website: www.rcm.org.uk

Royal College of Nursing

The Royal College of Nursing (RCN) represents nurses and nursing, promotes excellence in practice and shapes health policies. It supports and protects nurses and nursing staff, represents their interests professionally, and protects their terms and conditions of employment in all employment sectors.

Contact the RCN at:

Telephone: 020 7409 3333

Website: www.rcn.org.uk

Royal Pharmaceutical Society of Great Britain

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy.

Contact the RPSGB at:

Telephone: 020 7735 9141

Email: enquiries@rpsgb.org

Website: www.rpsgb.org.uk

Public Concern at Work

Since 1993 Public Concern at Work (PCaW) has been influencing the law and practice on whistleblowing at home and abroad. Recognised as an authority by governments, employers, unions and international bodies, Public Concern at Work provides advice on whistleblowing to individuals, organisations and communities.

Contact PCaW at:

Telephone: 020 7404 6609

Email: whistle@pcaw.co.uk

Website: www.pcaw.co.uk

UNISON

UNISON is Britain's biggest trade union. Members are people working in the public sector, for private contractors providing public services and in utilities. UNISON provides members with legal and welfare advice and employment representation. It is also a campaigning organisation.

Contact UNISON at:

Telephone: 0845 355 0845

Website: www.unison.org.uk

ANNEX 3

SOURCES CONSULTED IN THE PREPARATION OF THIS PUBLICATION

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

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

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

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

Department of Health (2003) **Equalities and Diversity: Strategy and delivery plan to support the NHS**. London: DH.

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4069546&chk=R3IOE8

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

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

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

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

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

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

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

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

A proposed approach to assessing the performance of healthcare organisations.

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

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

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

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

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

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

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

A review and recommendations about managing suspensions from clinical service.

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

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

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

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

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

Essential code for nurses and midwives.

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

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

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

Outlines the work of the NHS Employers organisation.

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

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

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

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

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

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

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

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

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

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

Useful guidance for practitioners about whistleblowing.

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

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

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

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

Royal Pharmaceutical Society of Great Britain (2005) ***Identifying and Remedying Pharmacist Poor Performance in England and Wales***. London: RPSGB.

Available at: <http://www.rpsgb.org.uk/pdfs/pharmpoorperf0501.pdf>

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

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

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

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National Patient Safety Agency

National Clinical Assessment Service

How to conduct a local performance investigation



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Introduction

Purpose

The National Clinical Assessment Service (NCAS) is often asked for advice about local investigations into practitioner performance or conduct. While there are no firm rules about when to investigate or how, as each case has to be considered in relation to its own facts and circumstances, there are principles which can be followed in all sectors of healthcare and for any healthcare profession.

Identifying and dealing with performance problems promptly and efficiently can reduce potential risk for patients, practitioners and the teams they work in, as well as for the service as a whole. This guide suggests what this might mean for investigations. It follows the sequence of an investigation from first notification of a concern to the point at which findings are made available to decision-makers. It is written for both primary care organisations (PCOs) and organisations providing hospital and community (H&C) services, in both the NHS and independent sectors of healthcare.

Assumptions

As part of its governance programme, every organisation should have performance procedures which are objective, fair, up-to-date and easily accessed by anyone interested in them. Formal procedures should comply with core legislation and guidance. Organisations should aim to have managers trained to use the procedures and people identified as potential investigators and case managers so that investigations can proceed promptly, when needed. By assuming that local procedures and processes are in good order, this guidance can focus specifically on the investigating process. Other NCAS publications and guidance can be used to review local processes, if necessary, and managers can also ask NCAS advisers for help.

We have also assumed an understanding that guidance of this sort can cover only general principles and that the handling of a specific case must depend on the unique facts of that case. Where template formats are shown, these are illustrations of the types of issues and actions to consider; organisations should take legal advice, where necessary.

Relationship with other NCAS guidance

This guidance is written to be used alongside other NCAS publications including *Handling performance concerns in primary care* (2010). We have built on earlier NCAS guidance in *Local GP Performance Procedures* (2007) (now replaced by *Handling performance concerns in primary care*) and also on the joint Department of Health and NCAS publication *Handling Concerns About The Performance of Healthcare Professionals: Principles of Good Practice* (2006).

Further NCAS guidance can be downloaded from: www.ncas.npsa.nhs/toolkit

For current NCAS publications go to: www.ncas.npsa.nhs.uk/resources/publications/key-publications

Terms

'Organisation': a healthcare organisation employing or contracting with health practitioners.

'Investigation': an inquiry carried out by a healthcare organisation into whether or not there is a problem to address in a practitioner's performance.

'Practitioners': dentists, doctors and pharmacists, the groups within NCAS' current remit, although organisations may find the guidance useful in other contexts as well.

'Performance concerns': any aspects of a practitioner's performance or conduct which:

- pose a threat or potential threat to patient safety;
- expose services to financial or other substantial risk;
- undermine the reputation or efficiency of services in some significant way;
- are outside acceptable practice guidelines and standards.

A glossary of other terms can be found on page 23.

Legal framework

Statutory Instruments ('regulations') and frameworks differ from country to country and across the professions, so it is important to access the relevant legislation and guidance. The 'Must knows' sections on the NCAS website provide quick links to key NHS legislation in each country and for each practitioner group.

See www.ncas.npsa.nhs.uk/mustknows

Feedback

Feedback about this document would be greatly valued. Please send it to: ncas@ncas.npsa.nhs.uk

This is a guidance document but NCAS can be contacted at any stage for advice about the handling of specific cases.

1. Deciding whether to investigate

Performance concerns can come to light in many ways, including routine monitoring of management information, reports from patients and colleagues, appraisal, reports on serious untoward incidents and anonymous complaints or concerns. Anonymous reports may be difficult to verify but should not be dismissed. It is unlikely that on their own they would support formal action, but they may lend support to other evidence.

Any performance concern raises the possibility of a need for further investigation. This section outlines how to decide whether to conduct an investigation, by asking:

- What is a performance investigation?
- How might concerns be screened for investigation?
- What should be considered in making a decision to investigate?
- What are the alternatives?
- When is an investigation likely to be appropriate?

1.1 What is a performance investigation?

The purpose of a performance investigation is to determine whether or not there is a performance problem requiring action. A performance investigation is not a free-ranging inquiry. It is normally helpful to define the purpose of the investigation using terms of reference.

Terms of reference have to be determined based on what is known at the time an investigation is set up. If, later, a substantial issue comes to light that is outside the initial terms of reference, the terms can be reviewed and, if necessary, changed to ensure that the investigation covers the new issue.

An investigation report then sets out findings and the evidence on which the findings are based. The report informs a decision on whether to take action on the concern and how. It does not make the decision.

A decision to investigate commits the organisation to significant work and expense, so the organisation needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

1.2 How might concerns be screened for investigation?

Regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. Anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

The form that screening takes will vary from organisation to organisation. The essential requirement is that a consistent process is followed, with decisions made by a person or group with appropriate authority. Decisions made should be appropriately recorded and the practitioner kept informed of progress.

In *Handling performance concerns in primary care*, NCAS suggests the use of a decision-making group (DMG) supported by a professional advisory group (PAG), with membership suggestions made for both groups. In a primary care organisation (PCO) using this structure the DMG would usually make the decision to commission a local investigation or to take some other action such as referral to the police or counter fraud agency. In secondary care, it is the designated responsible manager (often the medical director or deputy) who will determine (in consultation with others, as appropriate) whether or not an investigation is required. In both sectors, the interface with responsible officers for medical practitioners (once appointed) will need to be considered.

The purpose of screening is to identify whether there are *prima facie* grounds for an investigation and, if there are, to set terms of reference which are sufficiently detailed for the investigation to proceed. It is essential that managers set aside dedicated time to progress initial screening so that it can be completed properly and quickly.

1.3 What should be considered in making a decision to investigate?

Before deciding whether a performance investigation is necessary, consider what other relevant information is available. This could include:

- clinical or administrative records;
- serious untoward incident reports or complaints;
- earlier statements or interviews with people with first-hand knowledge of the concern;
- clinical audit and clinical governance data;
- the views of appropriate professional advisers;
- earlier occupational health reports.

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

There will normally need to be input from the practitioner too. As a general principle, NCAS encourages employers and contracting bodies to be transparent and to communicate and engage early with the practitioner whose performance is causing concern. NCAS suggests that the case manager or other appropriate person should have a preliminary meeting with the practitioner, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses. The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police advise that early meetings or early disclosure could compromise subsequent investigations. But generally, the practitioner's response will be helpful in deciding whether to carry out an investigation.

1.4 What are the alternatives?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the following circumstances:

- The practitioner may agree that the concerns are well-founded and agree to cooperate with required further action. However, if the issues raised are serious enough to suggest that if upheld they might warrant consideration of termination of employment or removal from a performers list, then the organisation may still need to conduct an investigation. The action to be taken subsequently would then be decided in the normal manner.

- Confirmed or suspected ill-health is another situation where performance investigation could be inappropriate. But health problems may be part of a more complex presentation where an investigation could still be helpful, so ill-health does not, by itself, rule out investigation. Information on a practitioner's health problems should remain confidential unless there are exceptional circumstances that require disclosure in the public interest.
- An investigation may also be judged unnecessary if the concerns are being investigated by another agency. An external investigation does not automatically preclude an NHS investigation but the organisation should have reasons for carrying out its own investigation into different aspects of potentially the same concern. There should then be close liaison with the other agency to avoid one investigation being compromised by the other.

The decision to proceed or not proceed with an investigation should be documented, with reasons, along with decisions on any alternative actions decided on. Box 1 shows what a meeting note might look like for a meeting where the decision is to defer investigation for the time being and take action straight away.

Box 1 – Recording a decision not to investigate, in primary care

This note sets out who decided what and why, and what has to happen next and when, with the note signed as a correct record by the chair. Similar records should be kept by the responsible manager in secondary care, showing the advice taken and the decisions made.

Note of meeting to consider whether to carry out an investigation into the performance of [practitioner] held on [date]

PRESENT: []

[Member] said that he knew [practitioner] through common membership of the local representative committee but he did not believe there was a conflict of interest. It was agreed that [member] should continue to take a full part in the proceedings.

The circumstances of the concern were then summarised by [the responsible manager]. The following information had come to the [organisation]'s attention, suggesting that [practitioner] might be performing below an acceptable standard in relation to [specified aspects of care]:

- Information from patients/carers [summarised, anonymised].
- Information from management monitoring sources [summarised].
- Information from colleagues/staff [summarised, anonymised].
- Other information [summarised, anonymised].

[Responsible manager] advised that there were no immediate reasons for thinking that patient safety was at risk. Also, [practitioner] was aware of the organisation's concerns and had indicated a willingness to undergo a remedial training programme on [aspect of care].

Remedial training arrangements have still to be established with [the postgraduate deanery] but similar measures have been used successfully in similar cases of performance concern within the organisation

It was agreed that:

1. The concerns are already clearly enough understood for action to be taken.
2. Provided remedial training can be put in place, further investigation is unnecessary at this time. This will be taken forward by [the responsible manager] working with [].
3. The case should be reviewed after [] months.
4. No immediate action is needed to protect patient safety.

Signed as a correct record by [Chair]

Date

1.5 When is an investigation likely to be appropriate?

Investigation will usually be appropriate where case information gathered to date suggests that the practitioner may:

- pose a threat or potential threat to patient safety;
- expose services to financial or other substantial risk;
- undermine the reputation or efficiency of services in some significant way;
- work outside acceptable practice guidelines and standards.

In these situations, a well-undertaken investigation and report will probably help to clarify any action needed.

In deciding to go ahead with an investigation the screeners and decision-makers should have a clear view on the areas of performance that are a concern – what is to be included and what is to be excluded. The decision-makers might not draft the terms of reference but they should approve them before the investigation starts. The terms of reference should also set report expectations and timescales.

The process of deciding whether to hold an investigation is summarised in Box 2.

Box 2 – Checklist for deciding whether to investigate

	Responsibility	Date
Concern identified and referred to responsible manager	Anyone	
Practitioner normally notified of concern	Responsible manager	
Written confirmation to practitioner	Responsible manager	
First meeting with practitioner	Responsible manager	
Meeting date agreed for decision-making group (if applicable)	Responsible manager	
Additional information assembled	Responsible manager	
Decision made on whether to investigate	Responsible manager or decision-making group	

2. Protecting and supporting

Chapter 1 ended with the decision to investigate. Before the investigation can proceed, even to the planning stage, certain protections must be considered for the people who will be involved in the investigation in any capacity. A formal investigation of practitioner performance is likely to impact on patients, carers, other healthcare workers, the practitioner's staff and colleagues, expert and other witnesses, not to mention the managers carrying out the investigation. Each needs some level of protection or support while the investigation is under way. Organisations should, as appropriate:

- protect patients from harm;
- protect people raising concerns;
- keep patients informed;
- support the practitioner;
- protect the organisation.

2.1 Protect patients from harm

Depending on the facts of a particular case it may be necessary to consider formal suspension (in primary care) or exclusion (in secondary care). Where possible, discuss such cases with NCAS before taking action. NCAS provides a 24-hour, seven day a week service to deal with situations of this sort. Specific procedures must be followed to ensure that a suspension or exclusion is lawful.

Suspension or exclusion should only be used where there is no reasonable alternative. These measures are often described as 'neutral' acts intended to protect patients, staff and the practitioner, and not to be disciplinary sanctions. In practice, the practitioner – and possibly colleagues – may see them differently. While exclusion or suspension do protect patients, they can make performance improvement more difficult.

As alternatives, an organisation might:

- ask the practitioner to withdraw voluntarily from carrying out certain duties;
- offer suitable alternative NHS work away from direct patient contact, whilst investigations continue.

Voluntary agreements should be put in writing. They should only be used as an alternative to formal action if detailed, clear and robust enough to give the same certainty of protection as formal action. A voluntary agreement could also state explicitly that the practitioner is entering into a formal undertaking which, if breached later, might lead to referral of the practitioner to the professional regulator. For non-contractor pharmacists, voluntary agreements remain the only available mechanism to restrict their practice.

Discussion with NCAS is advisable before use of a voluntary agreement to restrict practice. The practitioner should be advised to consult a defence society, union or solicitor before signing. Voluntary agreements are not appropriate where there are significant health difficulties or dishonesty is suspected. Apart from anything else, they may compromise an organisation's ability to take a formal position later that the practitioner was not fit to practise. Any information related to a practitioner's health or personal circumstances should normally remain confidential.

For the legal frameworks governing suspension and exclusion in each country go to www.ncas.npsa.nhs.uk/mustknows. Local guidance, regulations and ministerial directions (for example in England, *Maintaining High Professional Standards in the Modern NHS* (MHPS), Department of Health 2003) specify how practitioners must be notified that suspension or exclusion is being considered and given opportunity to make any representations.

For an outline voluntary undertaking to restrict practice, see Box 3.

Box 3 – Voluntary restriction of practice

Dear [Practitioner]

I am writing to confirm your undertaking today that with immediate effect and until further notice you will not provide any form of care to [specified patients], either at [normal workplace address] or at any other workplace.

You accepted that this is a formal undertaking and that if you breach the undertaking it would constitute professional misconduct and it would be appropriate for [organisation] to refer the breach to [professional regulator].

You will now have had opportunity to discuss this undertaking with your [defence society]. If you are still in agreement please confirm this by sending me the enclosed copy of this letter, signed and dated. If we do not receive this by [date] we will take formal action to protect patients.

Your undertaking will remain in force until our current investigation is complete. We will review it as part of the process of deciding the action to be taken (if any) in the light of the investigation's findings.

Yours sincerely

[Manager]

In situations such as this, the organisation may also need to consider whether to inform the relevant professional regulator. Regulators are concerned with issues that raise questions about a practitioner's fitness to practise. In its initial consideration of a case the healthcare organisation has a number of options, including referral to the regulator and other agencies. If it has been decided that a local performance investigation alone is required and, providing patient safety is assured, then there will be no reason to notify the regulator unless or until local proceedings identify serious concerns which bring into question the practitioner's capacity to practise at all. If in doubt, discuss the options with NCAS.

Where a practitioner giving cause for concern has resigned or been dismissed by the employer or is otherwise unavailable, the organisation may still decide to carry out an investigation to learn from the episode and, if possible, prevent it happening again. Where a practitioner moves away before performance concerns have been resolved, and is thought to pose a significant risk if re-employed elsewhere, organisations can also consider the issue of an alert notice. See www.ncas.npsa.nhs.uk/toolkit/disciplining/consider-who-else-needs-to-know for more advice on use of alert notices. Once issued, alert notices must be kept under review and rescinded as soon as they cease to be applicable. Alert notices are not issued in Scotland.

2.2 Protect people raising concerns

Whistleblowers and other people raising concerns about professional colleagues may feel vulnerable, particularly if still working with the practitioner concerned. As long as their concern is genuine, they should be protected by the organisation's local policy on whistleblowing and, where applicable, the *Public Interest Disclosure Act 1998* (PIDA). The organisation's human resources team could offer advice on the Act's provisions. Advice for individuals could also come from local representative committees, union or defence society advisers, or from professional regulators. The charity, Public Concern at Work (www.pcaw.co.uk) also offers confidential advice which can be accessed by people not employed by the organisation and therefore not covered by PIDA.

In practice, it is not usually possible to protect the identity of reporting practitioners, especially within small teams. Practitioners with potential performance concerns are likely to ask questions and try to guess the name of informant(s). They may make counter-allegations which will put working relationships under strain. Explaining the situation and the organisation's investigative procedures to both parties can help formalise the position and

prevent discussion within the team. Remind the practitioner and others involved in the investigation to avoid any action which could be seen as attempting to influence witnesses or influence the investigation in other ways.

Managers should recognise the stress that the practitioner may be under. At the same time, they must try to protect those around from further stress. If it becomes difficult for a team to continue functioning effectively then suspension or exclusion from work may have to be used, either against the practitioner whose performance is a concern or against another practitioner who is not treating the investigated practitioner reasonably.

Where witnesses ask to provide information anonymously, the investigator needs to strike a balance between the rights of the practitioner under investigation and the need to collect evidence. There are some circumstances where it may be possible to proceed even if the practitioner is not informed of the identity of witnesses. The important need is for the practitioner to know the evidence against them and the case they have to answer.

The courts have held anonymity to be reasonable in cases involving sexual misconduct or where there is a real or perceived risk of harm to the informant. In these circumstances the investigator should take a full statement from the witness and then anonymise it by erasing the parts which could identify the witness.

In other cases the investigator should explain why anonymous allegations are undesirable. So long as the concerns are genuine, the informant ought to be protected by any local policy on whistleblowing and, where applicable, by the provisions of PIDA.

When anonymous information is taken into account it is good practice for the investigator to record the issues considered and the reasons for allowing the informant to remain anonymous. The investigator should be available at any subsequent hearing to be cross-examined on the anonymous evidence and the reasons for anonymity.

2.3 Keep patients informed

Patients who are already aware of a concern (as complainants, for example) should normally receive the information provided for by the organisation's complaints handling procedure about the actions being taken and relevant timescales. Depending on the circumstances, it may be appropriate to brief patients more actively.

It would not be usual to release information about an ongoing investigation more widely to patients, unless some form of public announcement is necessary – in the event of a look-back exercise, for example. It would then be good practice to discuss a proposed information release with the practitioner first.

Information about a look-back will depend on the facts of the case. Whether a look-back exercise is necessary should be discussed with appropriate experts, for example in the relevant royal college or the Health Protection Agency. Patients whose care has to be reviewed should be contacted with an explanation of the medical need for the review and its implications. A contact point should be identified for further information. Where possible, a review exercise should not identify the practitioner concerned.

Media enquiries will usually go to named individuals within the organisation who have been trained and authorised to respond to them. The information provided to the media should not differ from the information which might have been given to individual patients. Care must be taken to preserve the confidentiality of patients and, where possible, the confidentiality of the practitioner.

The organisation will probably have local policies on media handling and on access to internal communications advice. Depending on the sensitivity of the issues, it could be appropriate to take external advice as well, to ensure that any information about the investigation reaches the media in the most appropriate way. Where possible, any information to be given to the media should be discussed with the practitioner in advance and the practitioner should have an opportunity to discuss the proposed statement with a union or defence society representative.

2.4 Support the practitioner

The practitioner was probably already told that an investigation might take place (see section 1.3). Once the decision to investigate has been taken, there should normally be another meeting, organised in the same way, with the practitioner offered the opportunity to be accompanied, and with a note of the meeting kept.

The meeting can, as appropriate, explain and allow questions about:

- Terms of reference, timescale, names of case manager(s) and investigator(s) and the process which the practitioner can use to respond to the concerns raised.
- The regulations and local procedures governing the case's handling. In England, for example, MHPS contains detailed guidance on investigation procedures while the Performers List Regulations do not specify how investigations should be conducted. The organisation therefore needs to be clear to the practitioner about which procedures it is applying.
- The reasons for any restrictions on practice or suspension/exclusion, with explanation of the potential consequences if requirements are not complied with. The relevant regulations set out notification requirements – see www.ncas.npsa.nhs.uk/mustknows
- Any proposed statements to patients, colleagues or the media, with the practitioner given enough time to discuss them with advisers/representatives. Ordinarily, colleagues would not have a direct need to know why the practitioner is under investigation or why they have been suspended or excluded from work. But some limited release of information may be appropriate and it is better if this can be agreed with the practitioner.
- The need for the practitioner not to attempt to influence potential witnesses – the same instruction going to everyone else involved in the investigation.
- Personal support mechanisms.

Being the subject of an investigation is likely to be very stressful for the practitioner. Support mechanisms could include access to occupational health services and professional psychological support or counselling. Managers should use occupational health services for advice on fitness to work or related questions about the practitioner's health. When making a referral to an occupational health physician, be explicit about the health issues which are causing concern. Use of GP or other routes does not prevent the occupational health physician giving advice on fitness for work, if necessary, provided there was a manager referral in the first place. If the practitioner self-refers to the occupational health service, the manager will not necessarily receive feedback.

Remember, when conducting an investigation, that it is likely the practitioner will continue working for the organisation afterwards so it is important to try to maintain an effective relationship throughout the process.

2.5 Protect the organisation

Keep in mind what could happen next and the need not to put investigators and decision-makers in positions where they might appear later not to be acting impartially, putting the organisation's actions at risk of challenge:

- People who might be involved in subsequent disciplinary proceedings or appeals should not be part of a decision to investigate or an investigation.
- People carrying out investigations should not be involved in later decisions to take formal action against a practitioner based on the investigation's findings.
- The position of the chief executive (CEO) should not be compromised. The responsible manager will need to report a serious concern to the CEO as the accountable officer, as soon as it is known about. But if local procedures mean that the CEO is likely to participate in subsequent formal decision-making processes (such as consideration of list removal or exclusion/suspension), the CEO should only be told the broad nature of the concerns.
- Sometimes a practitioner whose performance is causing concern may complain of bullying or harassment. Such complaints should be investigated in accordance with local policies, but overseen by a manager who is not otherwise involved in handling the concern.

3. Managing the investigation

The investigation starts once its terms of reference are finalised and when a case manager and investigator(s) have been appointed. Once the decision is taken to hold an investigation there should normally be discussion with the practitioner to secure as much engagement as possible. The practitioner should be made aware of the terms of reference and who the proposed case manager and investigator(s) are so that any objections can be raised.

The organisation can then:

- finalise terms of reference;
- appoint a case manager;
- appoint case investigator(s).

The investigator(s) will:

- collect evidence;
- interview the practitioner;
- weigh the evidence and identify the facts of the case.

3.1 Finalise terms of reference

These will have been agreed in outline at the time a decision was made to carry out the investigation, but some final drafting may be needed. The terms of reference as finally drafted should be agreed by the organisation's relevant decision-maker(s). The case manager and investigator(s) appointed to manage and carry out the investigation (see next sections) would not normally be involved in this process.

Terms of reference should be tight enough to prevent an unfocused general investigation of everything concerning the practitioner. It may be appropriate to specify areas not to be investigated as well as the areas where evidence and commentary are expected. Box 4 suggests a format.

Box 4 – Terms of reference for an investigation

An investigation is commissioned into the performance of [practitioner's name], working as a [practitioner's job title] for [organisation's name], at [workplace address].

The matters to be investigated are [].

The following matters are excluded from the investigation [].

It is expected that the investigation will be completed by [date] and that a report will be submitted to [named manager] by [date].

The report should detail the investigation's findings of fact and include a commentary on how the performance of [practitioner's name] compares with that expected from a practitioner working in similar circumstances.

As a minimum, terms of reference should set out:

- the issues to be investigated;
- the period under investigation;
- the timescale for completion.

It may be that as the investigation progresses the terms of reference are found to be too narrow or that new issues emerge that warrant further investigation. In such cases, the investigator(s) should inform the case manager who should seek the agreement of the responsible manager or DMG to a widening of the terms. Such requests should be decided on promptly so that the investigation is not delayed. The practitioner must be informed of any changes to the terms of reference unless, exceptionally, he is kept unaware of the investigation at all.

3.2 Appoint a case manager

A case manager is normally appointed by the DMG (in primary care) or the responsible manager (in the H&C sector). Usual practice is for a case manager to be a senior member of the organisation's staff, with a role to:

- ensure that the investigation is conducted efficiently;
- ensure that confidentiality is maintained where appropriate;
- act as the coordinator between investigators, the practitioner and anyone who the investigators need to interview;
- obtain any documentation required;
- ensure that the process is properly documented;
- receive the investigator's report;
- make recommendations to the responsible manager or the DMG on what action might follow, having regard to the contents of the investigator's report.

To be seen to be objective, case managers need to be able to demonstrate that they:

- understand the general nature of the concerns raised and the clinical and work contexts in which they occurred;
- are sufficiently senior within the organisation to secure the cooperation of other staff members;
- are familiar with the local policy for investigating concerns and related procedures;
- have, preferably, some training and experience in undertaking performance investigations;
- have access to relevant advice and expertise from colleagues within the organisation;
- have access to relevant external experts and authority to instruct them;
- have the necessary protected time to support the investigation.

The case manager should have no real or perceived conflict of interest in relation to any aspect of the investigation. Given the structure of the NHS and the small size of some organisations, minor conflicts of interest are difficult to avoid. Any reservations about the choice of a case manager ought to be reported to the DMG or responsible officer at the outset so that a decision can be made about their significance. The practitioner's views should also be taken into account.

In England, MHPS requires that the medical director should act as case manager for cases involving clinical directors and consultants.

3.3 Appoint case investigator(s)

Normal practice is for the investigative work to be carried out by a second senior staff member, or possibly more than one. An investigator's role is to collect and examine relevant evidence and complete the investigation in line with its terms of reference. The investigator will ask the practitioner for a response to the concerns raised, resolve any conflicts of evidence, determine the facts and produce a report which accurately captures all relevant details and findings. All investigators also have a duty to maintain confidentiality and ensure that the investigation is documented.

Usually investigators can be identified within the organisation but occasionally it is necessary to commission an external expert where a suitable person is not available internally. All investigators must be asked to confirm at the outset that there are no real or perceived conflicts of interest disqualifying them from doing the work in question. As for case managers, it may not be possible to identify an investigator totally without knowledge of the practitioner in some administrative capacity. As for case managers, any doubts about impartiality should be raised at the outset.

When asked to undertake an investigation, investigators should be able to demonstrate that they:

- have the necessary expertise to conduct the investigation. In the event that the nominated investigator does not have a relevant clinical background they should ensure that they obtain appropriate advice where issues of clinical judgement are raised. If there are no other senior clinicians with the relevant expertise, a senior clinician from another NHS body should be involved;
- understand the work context of the practitioner;
- have time to complete the investigation and report in a reasonable timescale.

Where more than one investigator is instructed, a lead investigator should be nominated to lead the investigation, ensure compliance with the terms of reference and complete the report.

3.4 Collect evidence

Evidence needs to stand up before an impartial tribunal. It includes written materials such as patients' clinical records and other organisation records, appraisals or other information held on the practitioner's personal file which is relevant to the investigation, as well as oral and written evidence provided by witnesses to specific events and any other relevant factual information. The practitioner is also a witness.

An investigation will often begin with a planning meeting between the case manager and investigator(s) to determine, for example:

- what documents need to be seen;
- who will be interviewed;
- how to manage administration of the investigation;
- means of communication with the practitioner;
- other logistical issues.

The investigating team will need to take a view on whether patient records need to be accessed to assist the investigation. Normally this will require prior patient consent but in certain circumstances there can be a public interest justification for disclosure without consent. It may be necessary to take advice from the organisation's Caldicott Guardian in the first instance, and possibly also from the organisation's legal advisers.

Once collected, evidence must be stored safely. Attempts to alter evidence can be prevented if original documents are obtained as soon as possible, and kept securely. Where it is necessary to give the practitioner access to documents, they should be provided as copies or viewed under supervision.

For guidance on conduct of interviews, including use of the PEACE model (Preparation and planning, Engage and explain, Account, Closure and Evaluation) go to: www.ncas.npsa.nhs.uk/toolkit/investigating/train-investigators/resources

The investigator should remain objective and avoid leading the witness through inappropriate feedback or comment. At the end of the interview the witness should be asked if there is anything else that they wish to add to the evidence that they have given. Following the interview, witnesses should be given a comprehensive note and asked to confirm that it is an accurate record of their interview. Alternatively, it is open to the healthcare organisation to commission its legal advisers to obtain a formal witness statement.

In general, there is no need for witnesses to be accompanied. If a witness requests a friend or supporter to be present, the investigators may allow this but the friend should take no part in the interview and should not answer questions or make statements on the witness's behalf.

Accurate records should be kept of all interviews. Interviewees may feel inhibited by the use of recording equipment. If recording is proposed, do not turn the equipment on until the interviewee has agreed to its use. Explain why you would prefer to use it, who will be entitled to listen to it and how long the recording will be retained before being erased. If the witness does not agree, have a note taken by a second person, so that the investigator can concentrate on asking questions.

See Box 5 for an example of how a witness statement might be set out. There are several ways of putting witness statements into writing. It may be appropriate for some witnesses to write their own statements. But it is also acceptable for the investigator to question, take notes and then draft the witness statement, using the witness's own words so far as possible. The witness can then check the draft, ask for alterations to be made, if necessary, and sign the statement as an accurate record.

Box 5 – A witness statement format

Investigation reference number

Statement made by [witness] to [investigator] after interview on [date].

This statement was drafted on my behalf by [investigator] and I have confirmed its accuracy, having seen it in draft and having been given an opportunity to make corrections or additions.

The investigator told me the terms of reference of the investigation and asked me questions about [].

The investigator also showed me [] and asked me to comment on [] attached [] to this statement.

I said [facts of the case as known to the witness, in chronological order].

I said that [] also [observed the event in question] and could corroborate this statement.

I believe that the facts in this statement are true.

Signed

Date

3.5 Interview the practitioner

Precisely what information will be given to a practitioner under investigation will depend on the circumstances of the case and on any relevant rules, regulations and procedures governing its handling. The investigator must be free to collect evidence without being pressurised by the practitioner or the practitioner's representative.

Assuming it is appropriate for the practitioner to know that the investigation is taking place (that is, no advice against telling the practitioner has been given by the police or a fraud agency), the practitioner should be invited to provide any information thought relevant to the matters under investigation. This might include documentary evidence as well as identifying witnesses, and providing oral evidence. The investigator(s) should take account of

any evidence provided by the practitioner which is consistent with the investigation's terms of reference. It may be appropriate for the practitioner to be interviewed twice, at the start of the investigation (see also 1.3) and at the end when all other evidence has been collected. The first interview gives the practitioner an opportunity to comment on the investigation process while the second allows the practitioner to be questioned about information likely to be used in the investigation report.

Prior to being interviewed the practitioner might request sight of the evidence on which the investigator(s) propose to rely in their report. This would normally be permitted, once the evidence has been collated into its final form. England's MHPS says that the practitioner must be shown a copy of the investigator's report in capability cases but this is not a requirement in MHPS conduct cases. Local procedures will need to be clear as to what, if any, access the practitioner will be given to the investigator's report to correct any matters of factual error before its submission to the case manager for consideration.

The *Employment Relations Act 1999* gives employed practitioners the right to be accompanied by a union/professional body representative or by a work colleague. While that person might speak on behalf of the practitioner, the practitioner must answer any specific questions put to them about their own actions. Many organisations also allow a friend, partner or spouse to provide support to the individual in a similar manner. In England, where MHPS has been adopted, employed practitioners have an additional right to a legally qualified representative.

For practitioners whose cases are being investigated under Performers List Regulations, there are no statutory provisions on how an investigation should be conducted but it is good practice, where possible, to give such practitioners the same opportunities to be supported as employees.

A practitioner cannot be compelled to attend an investigation interview or answer questions but, in general, the only justification for declining to answer questions is that to do so would be incriminating. Failure to attend an interview or cooperate may in itself warrant further action. Professional regulators expect practitioners to cooperate and contribute to local inquiries to help reduce risk to patients, so regulator referral may be an option for the organisation where non-cooperation arises.

Not answering questions denies the practitioner the opportunity to ensure that their own account of events is properly presented to the investigators. The practitioner's own account of events might still be presented at any later hearing that might arise.

3.6 Weigh the evidence and identify the facts of the case

Having collected the evidence, the investigator(s) should set out the facts as they see them, weighing the evidence on the balance of probabilities and taking as true anything which appears more probable than improbable. The more serious the concerns about the practitioner, the greater the need for the investigators to satisfy themselves that the evidence supports their findings of fact.

Investigators will need to take positions on:

- **Written versus oral evidence:** while written evidence may be more clearly defined, oral evidence can be tested by questioning and could be taken as equally reliable, depending on the circumstances. Written witness statements are best compiled in the words of the witness and signed and dated. Both forms of evidence are best collected as soon as possible after the events in question.
- **Age of evidence:** apart from determining what is meant by 'old' in local proceedings, it might be considered that a pattern of unacceptable performance (including conduct) over a period of time is likely to be more significant evidence than an isolated incident even if occurring recently.
- **Seeing the event itself or seeing the aftermath:** factual evidence ought to carry most weight. Opinions of witnesses and unsupported anecdotal evidence are likely to have limited use.
- **Technical competence:** where the investigator identifies a need for specialist advice to interpret a technical issue outside their expertise, the case manager should make arrangements for it to be provided so that evidence is appropriately interpreted.

- **Evidence from previous investigations:** all relevant evidence should be considered, including previous complaints and investigations where relevant, provided there are adequate records of the events and actions that were taken at that time, or matters were of a serious nature such that they continue to have a relevance to the matters now under investigation and can usefully form part of the investigators' report.

In order to be able to demonstrate a fair process, if there is any uncertainty about how to treat a specific piece of evidence, advice should be sought from the healthcare organisation's legal adviser.

Some conflicts of evidence are probably inevitable as individuals present different accounts of the same events. Not all conflicts of evidence need to be resolved, only those that affect the investigators' findings of fact about the performance concerns being investigated.

Normally, independent accounts which corroborate each other are likely to be preferred to disparate accounts of the same incident, or similar accounts provided by people known to be antipathetic to the practitioner under investigation. In drafting their report, investigators should record material conflicts of evidence stating which version of events they preferred and why.

3.7 Manage the timetable

MHPS states that the case investigator should aim to complete the investigation within four weeks of appointment and submit a report to the case manager within a further five days. In more complex cases it may not be possible to do this. But it is good practice to try to complete investigations within a reasonable timescale taking into account the circumstances of the individual case. Delays are damaging to the healthcare organisation, the practitioner, and to other staff and patients. The investigation process can lose momentum and become stale. Active management of the process by the case manager is essential if delays are to be avoided.

Where key individuals are difficult to contact and interview, all reasonable steps should be taken to accommodate their other commitments. Case managers should receive the full support of senior management in overcoming any delays.

Practitioners who are unavailable should be given a reasonable opportunity to participate in the process, which may involve close liaison with their representative. The representative will be aware that failure to cooperate means that the practitioner's oral or written account of events may not be received by the investigators in time to influence the report.

Where a practitioner's current health status is preventing their participation in the investigation process, an occupational health assessment might be offered to ascertain whether, whilst they may not be fit to return to work, they are well enough to be interviewed.

All this adds up to a checklist for monitoring the investigation's progress, once started – see Box 6 (page 18).

Box 6 – Investigation checklist

	Responsibility	Date
Decision to investigate made	Decision-makers	
Practice restriction/suspension/exclusion considered	Decision-makers	
Case manager appointed	Decision-makers	
Investigator(s) appointed	Decision-makers	
Timetable finalised	Decision-makers	
Terms of reference finalised	Decision-makers	
Practitioner notified of decision to investigate	Case manager	
Practitioner notified of investigator arrangements	Case manager	
Meeting with practitioner to discuss arrangements	Case manager	
CEO told of arrangements made	Case manager	
Communication channels established (phone numbers etc)	Case manager	
Document requirements identified	Investigator	
Document storage system set up	Case manager	
Documents provided to investigator	Case manager	
Interviews identified	Investigator	
All interviews timetabled (including practitioner's)	Investigator	
First interview with practitioner completed (on process)	Investigator	
Note of first interview agreed	Investigator	
Interviews with other witnesses completed	Investigator	
Other witness notes agreed	Investigator	
Second interview with practitioner completed (on case)	Investigator	
Note of second interview agreed	Investigator	
Report in first draft for discussion with case manager	Investigator	
Report in second draft for accuracy check	Investigator	
Submission of report	Investigator	

4. Reporting

The final step is for the investigator to write a report – if possible within the five days suggested by MHPS. Like the rest of the investigation this will require dedicated time. The task will be easier if the case manager has organised a tight filing system to support the investigation. Consider the following:

- **documentation systems;**
 - **the report;**
 - **circulation;**
 - **next steps.**
-

4.1 Documentation systems

At the end of the investigation the organisation ought to have a comprehensive record of the information gathered during the investigation, with transcripts and witness statements where applicable. It is the case manager's responsibility to ensure that the investigation is documented and that all information held is identified and retrievable.

Case records should be kept securely and remain confidential. Electronic and hard copy records are equally acceptable. They should be handled in accordance with local and national data management requirements set out in the *Data Protection Act 1998* and the *NHS Code of Practice on Confidentiality* (Department of Health 2003). There is no nationally-set rule on retention periods for investigation records so organisations will need to determine their own retention periods for case documentation, taking into consideration local policies on, for example, retention of employment records.

During an investigation the practitioner may request access to relevant case papers, such as original clinical records which may form the basis of any questions to be posed by the investigator. It would be normal for such requests to be met.

4.2 The report

The key document is the investigator's report. This should be a self-contained document with enough information within it to inform a subsequent decision on whether concerns are unfounded or confirmed, whether or not further action is needed and, if so, the type of action to be taken.

The decisions would be made by a decision-making group of some description (in primary care) or (elsewhere) by the responsible manager in consultation with relevant senior colleagues and on the advice of the case manager. In primary care, available actions would be as provided for in performers list regulations. Elsewhere, action would either be under capability or conduct procedures, and the investigation would need to discuss the relevance of each of these procedures.

Wherever possible the report should exclude reference to identifiable individuals other than the practitioner. A suggested structure for an investigation report is shown in Box 7 (page 20). It will not be appropriate for every investigation but it shows how evidence can be set out in order to be as clear as possible and inform the decision-making process effectively.

Box 7 – A report template

Front cover

Strictly confidential

Organisation name

Report of investigation into concerns raised in relation to [practitioner's name and address]

Organisation's case reference number

Date

Contents page

Chapter headings with page numbers. Headings might include: Introduction, Background, The investigation, Methods, Findings of fact, Summary of conclusions.

The report can refer to annexes as necessary. Each document referred to should have a unique identifier. Where there are many documents it is helpful to categorise them by type – witness statement, clinical record, summary of witness interview, etc. The system will follow from the filing system set up at the start of the investigation.

Report

The report needs to set out the case story. The sections which will be appropriate will depend on the nature of each case but the following elements will normally need to be included somewhere:

- **Introduction:** brief introduction to the investigation, its relationship with any investigations by other bodies and the procedures and regulations governing the present investigation.
- **Background:** relevant career information about the practitioner and work with the organisation, with reasons for the investigation in more detail.
- **The investigation:** the specific allegations for investigation, the team carrying out the investigation (with names, job titles and qualifications), the terms of reference as set initially plus any subsequent amendments.
- **Methods:** for example, review of patient records, audit of a specific set of cases, prescribing reviews, interviews with specified patients and/or colleagues. If any expert witnesses were used, their expert credentials should be reported. There should be a list of all people interviewed and the capacity in which they were involved in the investigation.
- **Fact-finding:** what has happened, set out in chronological order and with supporting evidence identified. Where the fact-finding include the opinion of case investigators or other experts on a standard of care, the required standards of care should be quoted. The findings should draw attention to any conflicts of evidence and whether it was necessary to resolve the conflicts in order to complete the investigation. Grounds should be given for preferring one version of events to another.
- **Conclusions:** the conclusions reached on each of the points listed in the terms of reference, cross-referenced to the findings of fact.

Signed [Investigator(s)]

Date

4.3 Circulation

Circulation of the investigator's report is normally limited to the practitioner, case manager, members of the DMG (in primary care) or the responsible manager (elsewhere). In addition, and once appointed, a copy should also go to the responsible officer in England, Wales and Scotland. The DMG or the responsible manager may, at their discretion, consider whether it would be reasonable for the report subsequently to be seen by others.

The report should remain confidential. Where disclosure to any other person or body is deemed appropriate, disclosure should be kept to the necessary minimum and limited to specified individuals or bodies who are themselves under a duty of confidentiality about the information.

4.4 Next steps

At the conclusion of the investigation it is for the DMG or the responsible manager to determine what further action, if any, is required. There are many potential options, ranging from taking no further action or arranging local counselling and mentoring, to referral to the regulator or use of local disciplinary or capability procedures.

Once a decision has been reached the case manager should arrange to meet the practitioner to explain the outcome of the investigation. It remains open to the healthcare organisation to contact NCAS for further advice at any stage.

Glossary

Alert notice

Alert notices are used where a practitioner is believed to pose a serious potential or actual risk to patients or staff and who is believed likely to be working or seeking work elsewhere in a health or social care setting. See www.ncas.npsa.nhs.uk/toolkit/disciplining/consider-who-else-needs-to-know for advice on use of alert notices.

Area Professional Committees

In Scotland, Area Professional Committees are the statutory representative bodies for local practitioners. They are the equivalent of local representative committees in England, Wales and Northern Ireland.

Balance of probabilities

The balance of probabilities is the standard of proof required in most civil proceedings. It is met if allegations appear more likely to be true than not true.

Case investigator

A case investigator examines the relevant evidence in line with an investigation's terms of reference, determining findings of fact and producing a report.

Case manager

A case manager coordinates the investigation, organises its administrative support and tries to ensure that the investigation is completed to a timetable.

Clinical records

Clinical records include any information relating to the care or treatment of any current or former patient, including notes made by clinical staff, correspondence between clinicians, clinical photographs, video and audio recording, pathology results.

Confidentiality

Confidentiality is a legal obligation as well as a requirement of professional codes of conduct. It is also a specific requirement within NHS employment contracts and breaching confidentiality can lead to disciplinary action.

Counter fraud agencies

The NHS Counter Fraud and Security Management Service in England and Wales, and equivalent bodies in Northern Ireland and Scotland.

Decision-making group (DMG)

While procedures in primary care organisations vary, there will usually be a two-tier structure, with a performance advisory group (PAG) and a decision-making group (DMG). See NCAS guidance, *Handling performance concerns in primary care* (2010).

Defence societies

Amongst a range of member services, defence societies advise practitioners whose performance has caused concern.

Duty of cooperation

Practitioners have a professional and usually also a contractual responsibility to cooperate with investigations into standards of care and related issues. Only if cooperation could lead to incrimination are practitioners entitled to decline to answer questions.

Evidence

Evidence is the totality of the information relevant to the investigation to establish the facts about events. Evidence will come from a variety of sources and may be written or oral and in paper or electronic format.

Exclusion from the workplace

Exclusion from the workplace requires employees not to undertake their normal contractual responsibilities, usually on a temporary basis pending investigation and consideration of necessary further action. It is a precautionary measure, not a disciplinary sanction.

Fair process

Fair process means that the proceedings are conducted in a way that ensures that both sides have an opportunity to see and challenge all the evidence.

Lead investigator

See also 'Case investigator'. Where more than one case investigator is appointed, a lead investigator should be identified with responsibility to ensure that the investigation is completed as required under its terms of reference.

Local investigation

An investigation instigated and conducted by the organisation where the practitioner is working, as distinct from an investigation by a professional regulator, for example.

Local performance investigation procedure

A procedure published by the organisation and governing the conduct of local performance investigations.

Local representative committee

A generic term describing local dental committees, local medical committees, local pharmacy committees and also local optical committees. These are the groups representing the interests of primary care practitioners.

Look-back exercise

A retrospective review of the care provided to patients to determine if advice or treatment given was correct and safe, and whether further advice, investigation or treatment is required in response to any shortcomings identified during an investigation.

NHS Tribunal (Scotland)

The NHS Tribunal (Scotland) is an independent body established to ensure that NHS primary care services are not brought into disrepute by practitioners committing fraud, prejudicing its efficiency or similar behaviour.

Occupational health assessment

Occupational health services advise organisations and practitioners on work-related health issues, including advice on the effects of identified conditions on a practitioner's ability to perform certain roles and on general fitness to work.

Patient safety

Processes and procedures put in place to prevent avoidable harm to patients, including the identification of performance concerns about practitioners.

Performance advisory group (PAG)

A group giving expert advice on performance handling within a primary care organisation. See also 'Decision-making group'.

Performance assessment

Where local investigation has not produced enough information to identify a clear way forward, the organisation may consider a performance assessment. Assessments are undertaken by different bodies for different purposes. For information about NCAS assessments go to www.ncas.npsa.nhs.uk/about-us/whatwedo

Performance investigation

A performance investigation to determine whether or not there is a performance problem to be addressed. An investigation is not an assessment.

Personal conduct

Personal conduct includes aspects of behaviour that apply to all healthcare staff and include honesty, punctuality, civility, respect for patients and co-workers etc. See also 'Professional conduct'.

Professional conduct

Professional conduct describes the expected standards of behaviour for healthcare professionals. It includes all aspects of providing care for patients, working with colleagues and in teams, respecting the contribution of other health professionals, maintaining confidentiality and high professional standards.

Public Concern at Work Policy

A policy published by the organisation setting out the responsibility of employees and other to notify the responsible manager of concerns about patient safety or other matters threatening to undermine the integrity of the service. See also 'Whistleblowing'.

Public Interest Disclosure Act 1998

This Act provides some protection from dismissal and victimisation to employees raising genuine concerns about performance or conduct. In certain circumstances it will also provide redress.

See www.opsi.gov.uk/acts/acts1998/ukpga_19980023_en_1

Regulators

Regulators are statutory bodies responsible for the regulation of groups of health professionals and for establishing that practitioners are fit to practise. The General Dental Council, General Medical Council and General Pharmaceutical Council are all regulators.

Responsible manager(s)

A responsible manager decides what actions should be taken in response to a performance concern, on behalf of an organisation. This might include a decision to hold an investigation. The responsible manager will also decide the actions to be taken once an investigation is complete. It is common for the medical director or equivalent to fill this role.

Responsible officer

All practising doctors in England, Scotland and Wales are to be required to relate to a local 'responsible officer'. This will be a senior doctor with local responsibility for overseeing the revalidation process and handling complaints against doctors.

Restrictions on practice

A requirement or formal undertaking to limit professional practice to specific agreed areas or to define specific exclusions.

Separation of roles

No person involved in one stage of an investigation should take part in subsequent disciplinary proceedings or appeals based on the same set of facts. Separation of roles is an important element of securing fair process.

Soft information

Soft information does not have a firm evidential basis but nevertheless may contribute to the evaluation of concerns, if credible.

Suspension

Suspension is used in this guidance to describe an NHS procedure involving temporary removal of a practitioner from a performers list which prevents them performing the relevant list activities. It does not restrict their ability to practise in other settings. Only the regulator has the power to restrict registration pending investigation and further review. In all cases the on-going need to maintain a suspension must be kept under regular review. Note that terminology is not consistent across the UK, however, and 'suspension' sometimes describes 'exclusion' from employment.

Terms of reference

Terms of reference define the nature and purpose of an investigation, documenting its scope – what is included and what is excluded.

Whistleblowing

Whistleblowing means the raising of concerns outside normal organisation procedures because attempts to use the procedures appear to have failed. All organisations should have whistleblowing policies and procedures in place.

Witness

A witness of fact has first-hand knowledge about the event(s) in question and can help clarify issues for the investigators. An expert witness has specialist knowledge and can assist in the interpretation of events, standards of care or other relevant issues.

Other bodies who may be involved in performance investigation

Although most performance concerns can be investigated locally, some will require swift referral to the other agencies. NCAS can give advice on the appropriateness of referral to another body.

General Dental Council	www.gdc-uk.org CAIT@gdc-uk.org 0845 222 4141
General Medical Council	www.gmc-uk.org practise@gmc-uk.org 0845 357 0022
Royal Pharmaceutical Society of Great Britain (until General Pharmaceutical Council operational)	www.rpsgb.org enquiries@rpsgb.org 020 7735 9141
Pharmaceutical Society of Northern Ireland	www.psni.org.uk 028 9032 6927
General Pharmaceutical Council (expected to be operational Spring 2010)	www.pharmacyregulation.org 020 3365 3400
Family Health Services Appeal Authority	www.fhsaa.tribunals.gov.uk 0113 389 6061
Counter Fraud and Security Management Service	www.nhsbsa.nhs.uk/fraud 020 7895 4500
Counter Fraud and Probity Services Northern Ireland	www.hscbusiness.hsc.net 028 90 535574
NHS Scotland Counter Fraud Services	www.cfs.scot.nhs.uk 08000 15 16 28
Health Service Ombudsmen for England, Northern Ireland, Scotland and Wales	www.ombudsman.org.uk 0345 015 4033 www.ni-ombudsman.org.uk 0800 343424 www.spso.org.uk 0345 015 4033 www.ombudsman-wales.org.uk 01656 641150

At a glance

Deciding to investigate:

- What has happened? Is it isolated or are there linked incidents?
- What is the evidence and how much of it is corroborated?
- Are any other agencies involved? Should they be?
- Are there any health issues?
- Are there any patient safety or wider public interest protection issues that leave patients at risk?
- Which local procedures would govern an investigation?
- What would the terms of reference be? What might be included and excluded?
- Do we have trained investigator(s) available?
- What would the timescale be?
- Would an investigation report help us decide what to do next?

Questioning:

- Interview out of public gaze
- Frame questions around the concern(s) defined in the terms of reference
- Tell witnesses that it may be necessary to share the information provided
- Ask witnesses to corroborate or refute, based on what they themselves know
- Ask witnesses to sign off their statements

Reporting:

- Explain how the investigation came about and what has been done so far to manage the concern
- Identify the procedures which the investigation has complied with
- List the investigating team
- List witnesses
- List findings of fact
- Discuss any conflicting evidence and explain how conflicts were resolved

The National Clinical Assessment Service (NCAS) works with health organisations and individual practitioners where there is concern about the performance of a dentist, doctor or pharmacist.

We aim to clarify the concerns, understand what is leading to them and support their resolution. Services are tailored to the specific case and can include:

- expert advice and signposting to other resources;
- specialist interventions such as performance assessment and back-to-work support.

NCAS uses evaluation, data analysis and research to inform its work and also runs a programme of national and local educational workshops. Employers, contracting bodies or practitioners can contact NCAS for help. NCAS works throughout the UK and associated administrations and in both the NHS and independent sectors of healthcare.

Contact NCAS

In England **call 020 7062 1655**

In Scotland **call 0131 220 8060**

In Northern Ireland or Wales **call 029 2044 7540**

www.ncas.npsa.nhs.uk

National Clinical Assessment Service

National Patient Safety Agency
Market Towers
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SW8 5NQ

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

midwives nurses pharmacists
doctors healthcare scientists
dentists biomedical scientists
paramedics radiographers
orthoptists occupational therapists
chiropodists and podiatrists
clinical scientists art therapists
operating department practitioners
prosthetists and orthotists
speech and language therapists
physiotherapists dietitians

DH INFORMATION READER BOX

Policy
HR / Workforce
Management
Planning
Clinical

Estates
Performance
IM & T
Finance

Partnership Working

Document Purpose	Best Practice Guidance
ROCR Ref:	Gateway Ref: 6340
Title	Handling concerns about the performance of healthcare professionals: principles of good practice
Author	DH & National Patient Safety Agency
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Handling Concerns about the Performance of Healthcare Professionals: Principles of good practice

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

Handling Concerns about the Performance of Healthcare Professionals

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

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

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

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

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

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

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

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

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

Personal Information redacted by the USI

September 2006
London

1. INTRODUCTION

The aims of this publication and its intended audience

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

The document aims to:

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

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

In this document:

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

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

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

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

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

How the document was developed

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

What is covered

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

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

What is not covered

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

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

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

2. PRINCIPLES FOR HANDLING PERFORMANCE CONCERNS

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

Concerns about performance may relate to:

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

Principle 1 Patient safety must be the primary consideration

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

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

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

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

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

Policies for handling performance concerns should cover:

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

Principle 4 Avoid unnecessary or inappropriate exclusion of practitioners

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

Principle 5 Separate investigation from decision-making

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

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

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

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

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

Principle 8 Good human resources practice will help prevent performance problems

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

Good human resource practices include:

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

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

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

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

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

Principle 11 Commitment to equality and diversity

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

3. GOOD PRACTICE IN HANDLING CONCERNS

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

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

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

Receiving information about a concern

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

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

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

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

Considering the risk to patient safety

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

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

VIGNETTE

The importance of taking action early

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

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

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

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

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

Informing the practitioner

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

Support for the practitioner

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

Dealing with a concern informally

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

GOOD PRACTICE

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

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

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

Dealing with a concern formally

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

Gathering information – undertaking an investigation

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

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

Deciding what to do

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

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

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

Understanding contributory factors

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

THINK ABOUT:

The individual's health and other factors

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

Knowledge, skills and behaviour

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

The job

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

The work environment

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

Interventions and remedial action

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

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

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

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

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

VIGNETTE

Planned recovery and support for a pharmacist

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

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

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

VIGNETTE

Addressing a concern

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

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

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

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

VIGNETTE

Working beyond capacity

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

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

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

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

VIGNETTE

Informing the regulatory body

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

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

Review and supplementary action

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

Passing information

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

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

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

Aftermath and rehabilitation

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

GOOD PRACTICE

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

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

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

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

4. OTHER ISSUES TO CONSIDER

Role of the regulatory bodies

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

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

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

Questions to ask in considering referral to the regulatory body:

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

GOOD PRACTICE

Training to report a concern

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

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

Whistleblowing: raising a concern about a colleague's performance

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

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

Handling difficulties in teams

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

VIGNETTE

Adjusting teamwork to take into account individual needs

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

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

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

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

Using locums, agency and bank staff

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

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

Managing locum services

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

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

Equality and diversity

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

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

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

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

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

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

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

Conclusion

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

ANNEX 1

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

ANNEX 2

RELEVANT ORGANISATIONS

ACAS

ACAS provides a variety of sources of information and resources about producing disciplinary and grievance procedures. Resources include seven free e-learning programmes to help individuals and businesses on topics such as discipline and grievance, information and consultation. The site is accessible to both employers and employees.

Contact ACAS at:

Telephone helpline: 08457 474747

Website: www.acas.org.uk

British Dental Association

The British Dental Association (BDA) is the professional association and trade union for dentists in the UK. The BDA develops policies to represent dentists working in every sphere from general practice, through community and hospital settings, to universities and the armed forces.

Contact the BDA at:

Telephone: 020 7935 0875

Email: enquiries@bda.org

Website: www.bda-dentistry.org

British Medical Association

The British Medical Association (BMA) represents doctors from all branches of medicine all over the UK. It is a voluntary association, provides services for members, is an independent trade union and a scientific and educational body.

Contact the BMA at:

Telephone: 020 7387 4499

Website: www.bma.org.uk

The Centre for the Advancement of Interprofessional Education

The Centre for the Advancement of Interprofessional Education (CAIPE) promotes and develops collaboration between practitioners and organisations across the public services and is a resource for interprofessional education. It offers access to research and information and examples of good practice, conferences and it responds to policy documents.

Contact CAIPE at:

Telephone: 020 7554 8539

Email: admin@caipe.org.uk

Website: www.caipe.org.uk

Council for Healthcare Regulatory Excellence

The Council for Healthcare Regulatory Excellence (CHRE) is a statutory overarching body, covering all of the United Kingdom and separate from government, established in 2003. It promotes best practice and consistency in the regulation of healthcare professionals.

Contact the CHRE at:

Telephone: 020 7389 8030

Email: info@chre.org.uk

Website: www.chre.org.uk

General Chiropractic Council

The General Chiropractic Council (GCC) is a UK-wide statutory body with regulatory powers. Its duties are to regulate chiropractors, set standards for education, conduct and practice, and to develop and promote the profession of chiropractic.

Contact the GCC at:

Telephone: 020 7713 5155

Email: enquiries@gcc-uk.org

Website: www.gcc-uk.org

General Dental Council

The General Dental Council (GDC) is the organisation which regulates dental professionals in the UK.

Contact the GDC at:

Telephone: 020 7887 3800

Email: communications@gdc-uk.org

Website: www.gdc-uk.org

General Medical Council

The General Medical Council (GMC) registers doctors to practise medicine in the UK. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

Contact the GMC at:

Telephone: 0845 357 8001

Email: gmc@gmc-uk.org

Website: www.gmc-uk.org

General Osteopathic Council

The General Osteopathic Council (GOsC) regulates the profession of osteopathy, sets standards of osteopathic practice and conduct, assures the quality of education, ensures continuing professional education and helps patients with complaints about an osteopath.

Contact the GOsC at:

Telephone: 020 7357 6655

Email: info@osteopathy.org.uk

Website: www.osteopathy.org.uk

General Optical Council

The General Optical Council (GOC) is the statutory body which regulates dispensing opticians and optometrists and those bodies conducting business as optometrists or dispensing opticians. The GOC's main aims are to protect the public and promote high standards of professional conduct and education among opticians.

Contact the GOC at:

Telephone: 020 7580 3898

Email at: goc@optical.org

Website: www.optical.org

Health Professions Council

The Health Professions Council (HPC) regulates 13 professions: art therapists, biomedical scientists, chiropractors and podiatrists, clinical scientists, dietitians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, and speech and language therapists. The HPC sets standards covering health professionals' education and training, behaviour, professional skills, and their health.

Contact the HPC at:

Telephone: 020 7582 0866

Email: policy@hcp-uk.org

Website: www.hpc-uk.org

Independent Healthcare Advisory Services

The Independent Healthcare Advisory Services (IHAS) is a subscription-based service for independent healthcare providers which manages the independent sector complaints adjudication service and oversees the effective resolution of complaints.

Contact the IHAS at:

Telephone: 020 7379 7721

Personal Information redacted by USI

Website: www.independenthealthcare.org.uk

National Clinical Assessment Service

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

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

Contact the NCAS at:

Telephone: 020 7084 3850

Email: ncas@ncas.npsa.nhs.uk

Website: www.ncas.npsa.nhs.uk

National Patient Safety Agency

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

NPSA produces a range of publications including:

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

Contact the NPSA at:

Telephone: 020 7927 9500

Email: enquiries@npsa.nhs.uk

Website: www.npsa.nhs.uk

NHS Employers

NHS Employers is the employers' organisation for the NHS in England giving employers throughout the NHS an independent voice on workforce and employment matters. NHS Employers offers a range of events, publications and information.

Contact NHS Employers at:

Telephone: 0113 306 3000

Email: enquiries@nhsemployers.org

Website: www.nhsemployers.org

Nursing and Midwifery Council

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

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

Contact the NMC at:

Telephone: 020 7637 7181

Email: communications@nmc-uk.org

Website: www.nmc-uk.org

Royal College of Midwives

The Royal College of Midwives (RCM) is a trade union and professional organisation run by midwives for midwives. It provides leadership in midwifery, education and representation for members.

Contact the RCM at:

Telephone: 020 7312 3535

Email: info@rcm.org.uk

Website: www.rcm.org.uk

Royal College of Nursing

The Royal College of Nursing (RCN) represents nurses and nursing, promotes excellence in practice and shapes health policies. It supports and protects nurses and nursing staff, represents their interests professionally, and protects their terms and conditions of employment in all employment sectors.

Contact the RCN at:

Telephone: 020 7409 3333

Website: www.rcn.org.uk

Royal Pharmaceutical Society of Great Britain

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy.

Contact the RPSGB at:

Telephone: 020 7735 9141

Email: enquiries@rpsgb.org

Website: www.rpsgb.org.uk

Public Concern at Work

Since 1993 Public Concern at Work (PCaW) has been influencing the law and practice on whistleblowing at home and abroad. Recognised as an authority by governments, employers, unions and international bodies, Public Concern at Work provides advice on whistleblowing to individuals, organisations and communities.

Contact PCaW at:

Telephone: 020 7404 6609

Email: whistle@pcaw.co.uk

Website: www.pcaw.co.uk

UNISON

UNISON is Britain's biggest trade union. Members are people working in the public sector, for private contractors providing public services and in utilities. UNISON provides members with legal and welfare advice and employment representation. It is also a campaigning organisation.

Contact UNISON at:

Telephone: 0845 355 0845

Website: www.unison.org.uk

ANNEX 3

SOURCES CONSULTED IN THE PREPARATION OF THIS PUBLICATION

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

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

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

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

Department of Health (2003) **Equalities and Diversity: Strategy and delivery plan to support the NHS**. London: DH.

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4069546&chk=R3IOE8

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

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

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

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

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

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

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

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

A proposed approach to assessing the performance of healthcare organisations.

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

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

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

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

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

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

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

A review and recommendations about managing suspensions from clinical service.

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

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

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

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

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

Essential code for nurses and midwives.

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

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

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

Outlines the work of the NHS Employers organisation.

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

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

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

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

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

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

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

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

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

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

Useful guidance for practitioners about whistleblowing.

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

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

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

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

Royal Pharmaceutical Society of Great Britain (2005) ***Identifying and Remedying Pharmacist Poor Performance in England and Wales***. London: RPSGB.

Available at: <http://www.rpsgb.org.uk/pdfs/pharmpoorperf0501.pdf>

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

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

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

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www.ncas.npsa.nhs.uk



Maintaining High Professional Standards in the Modern
HPSS

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

Department of Health, Social Services & Public Safety
November 2005

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN HPSS

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

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INTRODUCTION

1. This document introduces the new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.
2. Throughout this framework where the term "performance" is used, it should be interpreted as referring to all aspects of a practitioner's work, including conduct, health and clinical performance. Where the term "clinical performance" is used, it should be interpreted as referring only to those aspects of a practitioner's work that require the exercise of clinical judgement or skill.
3. Under the Directions on Disciplinary Procedures 2005, HPSS organisations must notify the Department of the action they have taken to comply with the framework by 31 January 2006.
4. The framework is in six sections and covers:
 - I. Action when a concern first arises
 - II. Restriction of practice and exclusion from work
 - III. Conduct hearings and disciplinary procedures
 - IV. Procedures for dealing with issues of clinical performance
 - V. Handling concerns about a practitioner's health
 - VI. Formal procedures – general principles
5. Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist.

Background

6. There has been some concern in the past about the way in which complaints about doctors and dentists have been handled. Developing new arrangements for dealing with medical and dental staff performance has become increasingly important in order to address these concerns and to reflect the new systems for quality assurance, quality improvement and patient safety being introduced in the HPSS.
7. The National Clinical Assessment Authority (NCAA) was established to improve arrangements for dealing with poor clinical performance of doctors. The Department entered into a service level agreement with the NCAA in October 2004 to provide advice and guidance to the HPSS. Since April 2005,

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

8. The new approach set out in the framework builds on four key elements:
 - appraisal¹ and revalidation – processes which require practitioners to maintain the skills and knowledge needed for their work through Continuing Professional Development (CPD);
 - the advisory and assessment services of the NCAS – aimed at enabling HSS Bodies² to handle cases quickly and fairly - reducing the need to use disciplinary procedures to resolve problems;
 - tackling the blame culture – recognising that most failures in standards of care are caused by systems' weaknesses, not individuals per se;
 - new arrangements for handling exclusion from work as set out in Sections I and II of this framework.
9. To work effectively these need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists maintaining their competence; and which support an open approach to reporting and addressing concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through disciplinary action. However, it is not intended to weaken accountability or avoid disciplinary action where the situation warrants this approach.

The new framework

10. At the heart of the new arrangements is a co-ordinated process for handling concerns about the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS. Whatever the source of this information the response must be the same –
 - to ascertain quickly what has happened and establish the facts;
 - to determine whether there is a continuing risk;
 - to decide whether immediate action is needed to manage the risk to ensure the protection of patients;
 - to put in place action to address any underlying problem.

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

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

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

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

SECTION I. ACTION WHEN A CONCERN FIRST ARISES

INTRODUCTION

1. The management of performance is a continuous process to ensure both quality of service and to protect clinicians. Numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures.
2. Concerns about a doctor or dentist's performance can come to light in a wide variety of ways, for example:
 - concerns expressed by other HPSS staff;
 - review of performance against job plans and annual appraisal;
 - monitoring of data on clinical performance and quality of care;
 - clinical governance, clinical audit and other quality improvement activities;
 - complaints about care by patients or relatives of patients;
 - information from the regulatory bodies;
 - litigation following allegations of negligence;
 - information from the police or coroner;
 - court judgements; or
 - following the report of one or more critical clinical incidents or near misses.
3. All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to establish the facts and the substance of any allegations. Unfounded or malicious allegations can cause lasting damage to a doctor's reputation and career. Where allegations raised by a fellow HPSS employee are shown to be malicious, that employee should be subject to the relevant disciplinary procedures.

SUMMARY OF KEY ACTIONS NEEDED

4. The key actions needed at the outset can be summarised as follows:
 - clarify what has happened and the nature of the problem or concern;
 - consider discussing case with NCAS on the way forward;
 - consider if urgent action needs to be taken to protect the patient/s;
 - consider whether restriction of practice or exclusion is required;

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

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
 - arranging supervision of normal contractual clinical duties;
 - restricting the practitioner to certain forms of clinical duties;
 - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
 - sick leave for the investigation of specific health problems.
6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

7. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "*designated Board member*" should be involved to any significant degree in the management of individual cases.
8. The key individuals that may have a role in the process are summarised below:-
 - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
 - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

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

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

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
 - immediate telephone advice, available 24 hours;
 - advice, then detailed supported local case management;
 - advice, then detailed NCAS performance assessment;
 - support with implementation of recommendations arising from assessment.
10. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.
11. The first stage of the NCAS's involvement in a case is exploratory – an opportunity for local managers or practitioners to discuss the problem with an impartial outsider, to look afresh at a problem, and possibly recognize the problem as being more to do with work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.
12. The focus of the NCAS's work on assessment is likely to involve performance difficulties which are serious and/or repetitive. That means:

- clinical performance falling well short of recognized standards and clinical practice which, if repeated, would put patients seriously at risk;
 - alternatively, or additionally, issues which are ongoing or recurrent.
13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.
14. Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.
16. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.
17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.
19. An immediate time limited exclusion may be necessary
 - to protect the interests of patients or other staff;
 - where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.
20. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.
21. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.
22. The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting
23. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.
24. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.
25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

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

FORMAL APPROACH

28. Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CE must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.
29. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action.
30. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

The Case Investigator's role

31. The Case Investigator:
 - must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff³ with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;
 - must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator

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

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

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
 - must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
 - must assist the designated Board member in reviewing the progress of the case.
32. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.
33. The Case Investigator has wide discretion on how the investigation is carried out, but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

The Case Manager's role

34. The Case Manager is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority
35. The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.
36. If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another HSS body or elsewhere be invited to assist.

Timescale and decision

37. The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.
38. The report should give the Case Manager sufficient information to make a decision on whether:
- no further action is needed;
 - restrictions on practice or exclusion from work should be considered;
 - there is a case of misconduct that should be put to a conduct panel;
 - there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
 - there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
 - there are serious concerns that fall into the criteria for referral to the GMC or GDC;
 - there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

39. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.
40. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

TRANSITIONAL ARRANGEMENTS

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

SECTION II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

INTRODUCTION

1. This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.
2. In this part of the framework, the phrase “exclusion from work” has been used to replace the word “suspension” which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.
3. The Directions require that HSS bodies must ensure that:
 - exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
 - where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
 - all extensions of exclusion are reviewed and a brief report provided to the CE and the board;
 - a detailed report is provided when requested to the designated Board member who will be responsible for monitoring the situation until the exclusion has been lifted.

MANAGING THE RISK TO PATIENTS

4. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.
5. The purpose of exclusion is:
 - to protect the interests of patients or other staff; and/or
 - to assist the investigative process when there is a clear risk that the practitioner’s presence would impede the gathering of evidence.
6. It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

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

Key aspects of exclusion from work

8. Key aspects include:
- an initial “immediate” exclusion of no more than four weeks if warranted as set out in Section I;
 - notification of the NCAS before immediate and formal exclusion;
 - formal exclusion (if necessary) for periods up to four weeks;
 - ongoing advice on the case management plan from the NCAS;
 - appointment of a designated Board member to monitor the exclusion and subsequent action;
 - referral to NCAS for formal assessment, if part of case management plan;
 - active review by clinical and case managers to decide renewal or cessation of exclusion;
 - a right to return to work if review not carried out;
 - performance reporting on the management of the case;
 - programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
 - a right for the doctor to make representation to the designated Board member
9. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director.

Exclusion other than immediate exclusion

10. A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether there is reasonable and proper cause to exclude. **The NCAS must be consulted where formal exclusion is being considered.** If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.
11. The report should provide sufficient information for a decision to be made as to whether:
 - (i) the allegation appears unfounded; or
 - (ii) there is a misconduct issue; or
 - (iii) there is a concern about the practitioner's clinical performance; or
 - (iv) the complexity of the case warrants further detailed investigation before advice can be given.
12. Formal exclusion of one or more clinicians must only be used where:
 - a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of:
 - allegations of misconduct;
 - concerns around the functioning of a clinical team which are likely to adversely affect patients;
 - concerns about poor clinical performance; or
 - b. the presence of the practitioner in the workplace is likely to hinder the investigation.
13. Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.
14. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion

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

15. The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 19, and the need to remain available for work paragraph 20) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.
16. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.
17. If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.
18. If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

Exclusion from premises

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

Keeping in contact and availability for work

20. Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HPSS employer. This caveat does not refer to time for which they are not being paid by the HPSS employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).
21. The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

Informing other organisations

22. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HPSS and non-HPSS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer⁴.
23. Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HPSS, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.
24. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been

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

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

Existing suspensions & transitional arrangements

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

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

26. The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:
- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the Department (Director of Human Resources).
 - receive an assurance from the CE and designated board member that the agreed mechanisms are being followed. Details of individual exclusions should not be discussed at Board level.

Regular review

27. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive⁵. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.
28. The HSS body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

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

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

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

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

The role of the Department in monitoring exclusions

30. When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.
31. When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

RETURN TO WORK

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

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there is a case of misconduct that must be put to a conduct panel (paragraph 38 of section 1). Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.
2. It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraph 5 of Section IV refers).
3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.⁶
4. Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.
5. HSS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

CODES OF CONDUCT

6. Every HPSS employer will have a Code of Conduct or staff rules, which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:
 - a refusal to comply with the requirements of the employer where these are shown to be reasonable;
 - an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of

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

doctors and dentists by their regulatory body⁷;

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

EXAMPLES OF MISCONDUCT

7. The employer's Code of Conduct should set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Similarly the Labour Relations Agency (LRA) Code of Practice provides a non-exhaustive list of examples. Acts of misconduct may be simple and readily recognised or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.
8. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.
9. It is for the employer to decide upon the most appropriate way forward, including the need to consult the NCAS and their own sources of expertise on employment law. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively, or in addition, he or she may make representations to the designated Board member.
10. In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC.

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

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

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

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

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

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

Dropping of charges or no court conviction

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

SECTION IV. PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

INTRODUCTION & GENERAL PRINCIPLES

1. There will be occasions following an adequate investigation where an employer considers that there has been a clear failure by an individual to deliver an acceptable standard of care, or standard of clinical management, through lack of knowledge, ability or consistently poor performance. These are described as clinical performance issues.
2. Concerns about the clinical performance of a doctor or dentist may arise as outlined in Section I. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through local informal processes set out in Section I (paragraphs 15 – 17) **the matter must be referred to the NCAS before consideration by a performance panel** (unless the practitioner refuses to have his or her case referred).
3. Matters which may fall under the performance procedures include:
 - out moded clinical practice;
 - inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
 - incompetent clinical practice;
 - inappropriate delegation of clinical responsibility;
 - inadequate supervision of delegated clinical tasks;
 - ineffective clinical team working skills.

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

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

How to proceed where conduct and clinical performance issues are involved

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

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

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question⁸.
7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.
8. If the practitioner does not agree to the case being referred to NCAS, a panel hearing will normally be necessary.

HEARING PROCEDURE

The pre-hearing process

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

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

should be set for the hearing;

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

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.⁹ No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.
11. Arrangements must be made for the panel to be advised by:
 - a senior member of staff from Human Resources;
 - an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HPSS employer;

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

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

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

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

Representation at clinical performance hearings

13. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.
14. The practitioner may be represented in the process by a companion who may be another employee of the HSS body: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the clinical performance hearing

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

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

The order of presentation shall be:

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

Decisions

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

Possible decisions made by the clinical performance panel

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

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

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

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

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

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

17. A record of all findings, decisions and written warnings should be kept on the practitioner's personnel file. Written warnings should be disregarded for disciplinary purposes following the specified period.
18. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Given the possible complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.
19. The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

Introduction

20. Given the significance of the decision of a clinical performance panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process.
21. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel, in arriving at their decision, acted fairly and reasonably based on:
 - a fair and thorough investigation of the issue;
 - sufficient evidence arising from the investigation or assessment on which to base the decision;
 - whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

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

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

The appeal process

23. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.
24. Where the appeal is against dismissal, the practitioner should not be paid, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

The appeal panel

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

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool.¹⁰ This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust¹¹ who must also have the appropriate training for hearing an appeal.

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

26. The panel should call on others to provide specialist advice. This should normally include:
- a consultant from the same specialty or subspecialty as the appellant, but from another HPSS/NHS employer¹²;
 - a senior Human Resources specialist.

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

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

¹⁰ See Annex A.

¹¹ Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.

¹² Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

28. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original performance hearing. The following timetable should apply in all cases:
- appeal by written statement to be submitted to the designated appeal point (normally the Director of HR) within 25 working days of the date of the written confirmation of the original decision;
 - hearing to take place within 25 working days of date of lodging appeal;
 - decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.
29. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

Powers of the appeal panel

30. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.
31. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.
32. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

Conduct of appeal hearing

33. All parties should have all documents, including witness statements, from the previous performance hearing together with any new evidence.
34. The practitioner may be represented in the process by a companion who may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative

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

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

Decision

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

Action following hearing

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

Annex A**APPEAL PANELS IN CLINICAL PERFORMANCE CASES*****Introduction***

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.
2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held Northern Ireland wide list rather than through local selection. The benefits include:
 - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
 - the ability to monitor performance and assure the quality of panellists.
3. The following provides an outline of how it is envisaged the process will work.

Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with the Department, who will be responsible for administration of the list
5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the BMA, BDA, defence organisations, and the NCAS. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.
6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.
7. Panel members will be subject to appraisal against the core competencies and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.
8. The level of fees payable to panel members will be set by the Department and paid locally by the employer responsible for establishing the panel.

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

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

INTRODUCTION

1. This section applies when the outcome of an investigation under Section I shows that there are concerns about the practitioner's health that should be considered by the HSS body's Occupational Health Service (OHS) and the findings reported to the employer.
2. In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.
3. The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HPSS.

HANDLING HEALTH ISSUES

4. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)¹³. The practitioner may be accompanied to these meetings (as defined in Section I, para 30). Confidentiality must be maintained by all parties at all times.
5. The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.
6. In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures (as outlined in Section IV), or misconduct procedures (as outlined in Section III) would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer

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

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

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

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

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

Examples of action to take

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

DISABILITY DISCRIMINATION ACT (DDA)

9. Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.
10. Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non-disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

Examples of reasonable adjustment

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

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

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

SECTION VI. FORMAL PROCEDURES – GENERAL PRINCIPLES

TRAINING

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

HANDLING OF ILLNESS ARISING DURING FORMAL PROCEEDINGS

2. If an excluded employee or an employee facing formal proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside formal procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.
3. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner should have the opportunity to provide written submissions and/or have a representative attend in his absence.
4. Where a case involves allegations of abuse against a child or a vulnerable adult, the guidance issued to the HPSS in 2005, "Choosing to Protect – A Guide to Using the Protection of Children Northern Ireland (POCNI) Service", gives more detailed information.

PROCESS FOR SMALLER ORGANISATIONS

5. Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.
6. Such organisations should consider working in collaboration with other local HPSS organisations (eg other Trusts) in order to provide sufficient personnel

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

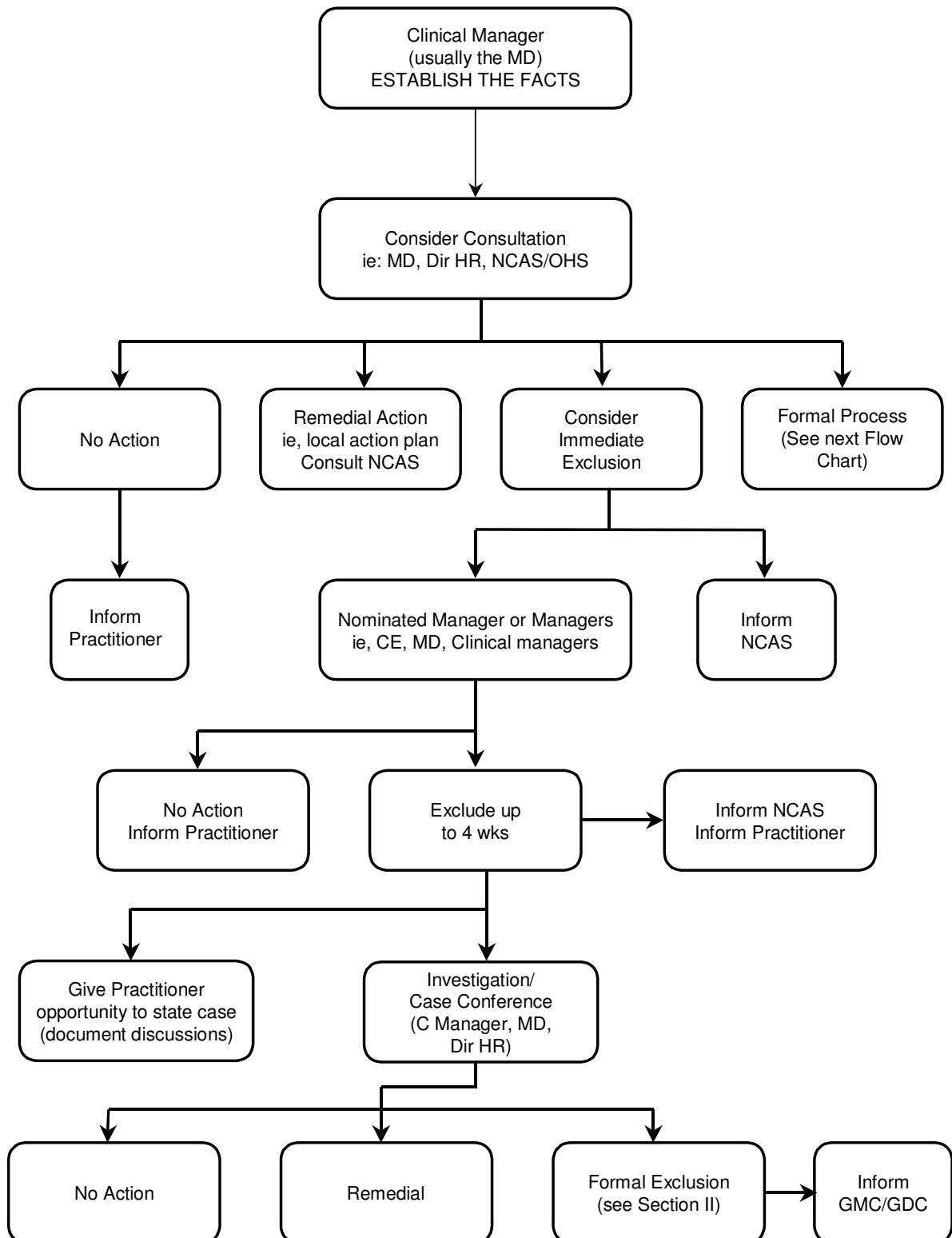
TERMINATION OF EMPLOYMENT WITH PROCEDURES UNFINISHED

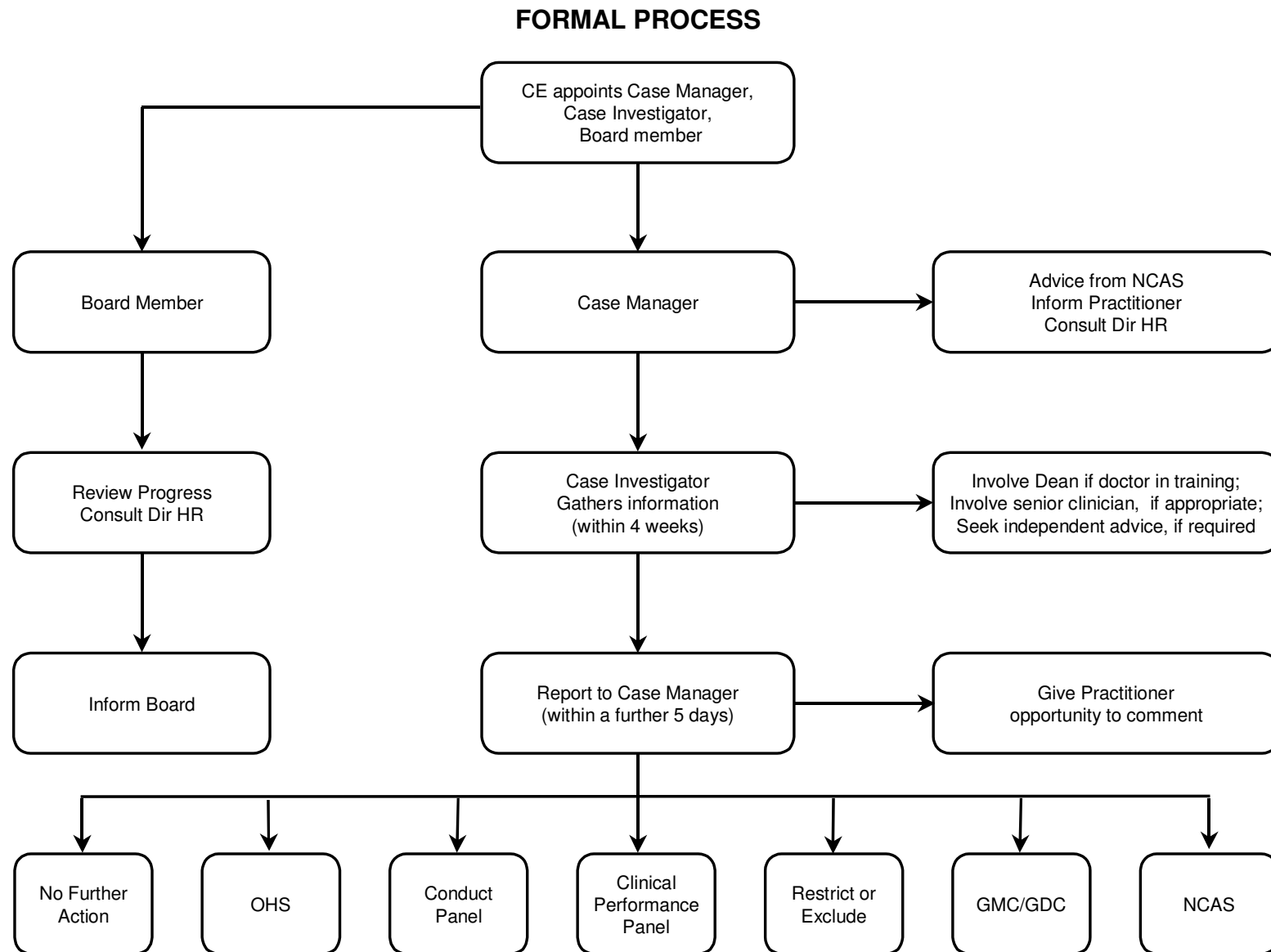
7. Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.
8. There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.
9. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning).

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

10. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:
 - settlement agreements must not be to the detriment of patient safety;
 - it is not acceptable to agree any settlement that precludes involvement of either party in any further legitimate investigations or referral to the appropriate regulatory body.

INFORMAL PROCESS







Southern Health
and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

23 September 2010

1.0 Introduction

- 1.1 Maintaining High Professional Standards in the Modern HPSS**
A framework for the handling of concerns about doctors and dentists in the HPSS (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.
- 1.2** This document seeks to underpin the principle within the MHPS Framework that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patient's harmed.
- 1.3** The MHPS framework is in six sections and covers:
- I. Action when a concern first arises
 - II. Restriction of practice and exclusion from work
 - III. Conduct hearings and disciplinary procedures
 - IV. Procedures for dealing with issues of clinical performance
 - V. Handling concerns about a practitioner's health
 - VI. Formal procedures – general principles
- 1.4** MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.
- 1.5** This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.
- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

1.6 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.7 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.8 This guidance should be read in conjunction with the following documents:

Annex A

“Maintaining High Professional Standards in the Modern NHS”
DHSSPS, 2005

Annex B

“How to conduct a local performance investigation” NCAS, 2010

Annex C

SHSCT Disciplinary Procedure

Annex D

SHSCT Clinical Manager’s MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1 NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also indicates that anonymous complaints and concerns based on ‘soft’ information should be put through the same screening process as other concerns.
- 2.2 Concerns¹ should be raised with the practitioner’s Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.
- 2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

¹ Examples of Concerns may include: - when any aspect of a practitioner’s performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

- 2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

- 2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expeditiously as possible and the Oversight Group will monitor progress.
- 2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following

informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

- 2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.
- 2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1

An informal process. This can lead to resolution or move to:

Appendix 2

A formal process. This can also lead to resolution or to:

Appendix 3

A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4

An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5

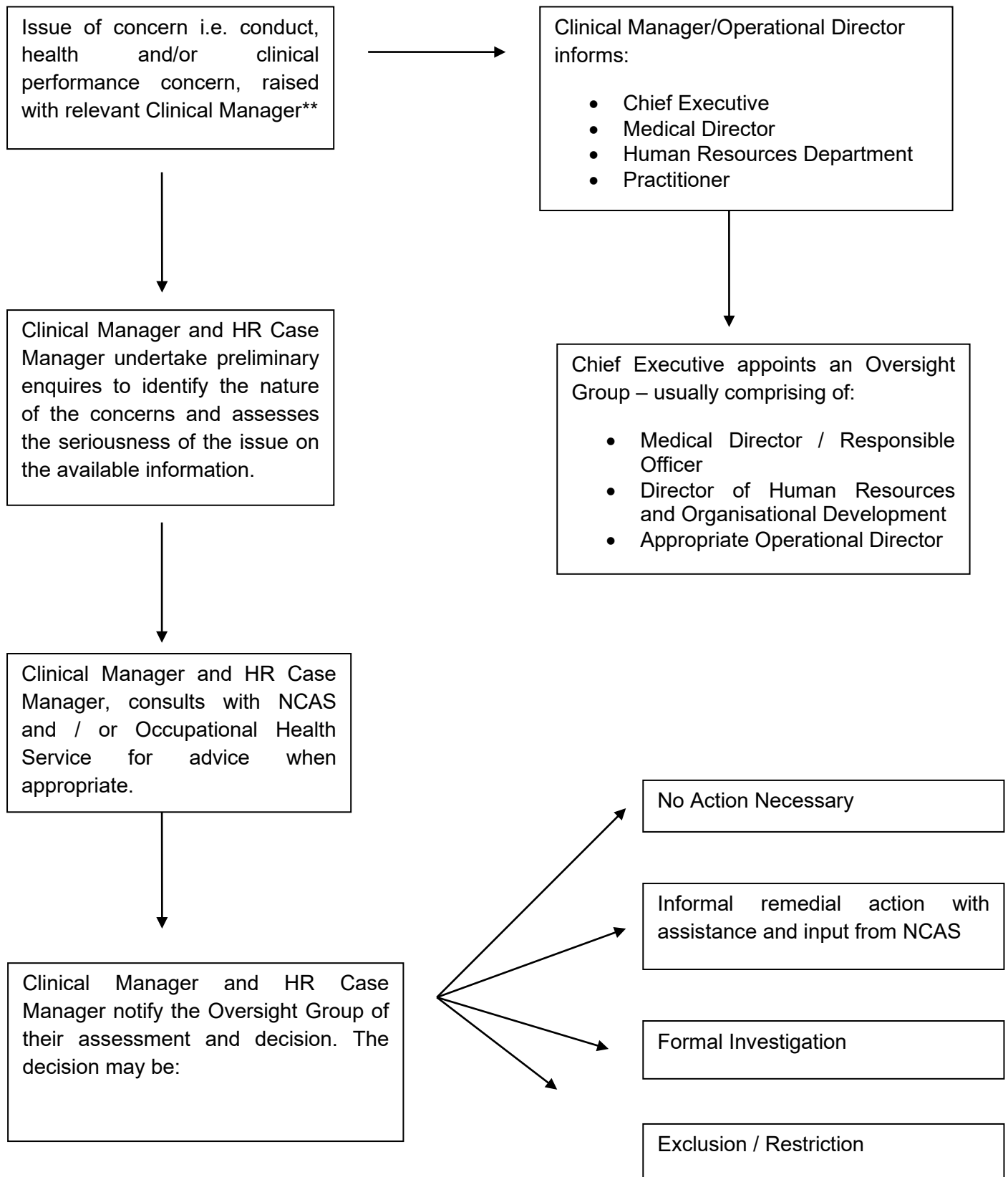
Exclusion can be used at any stage of the process.

Appendix 6

Role definitions

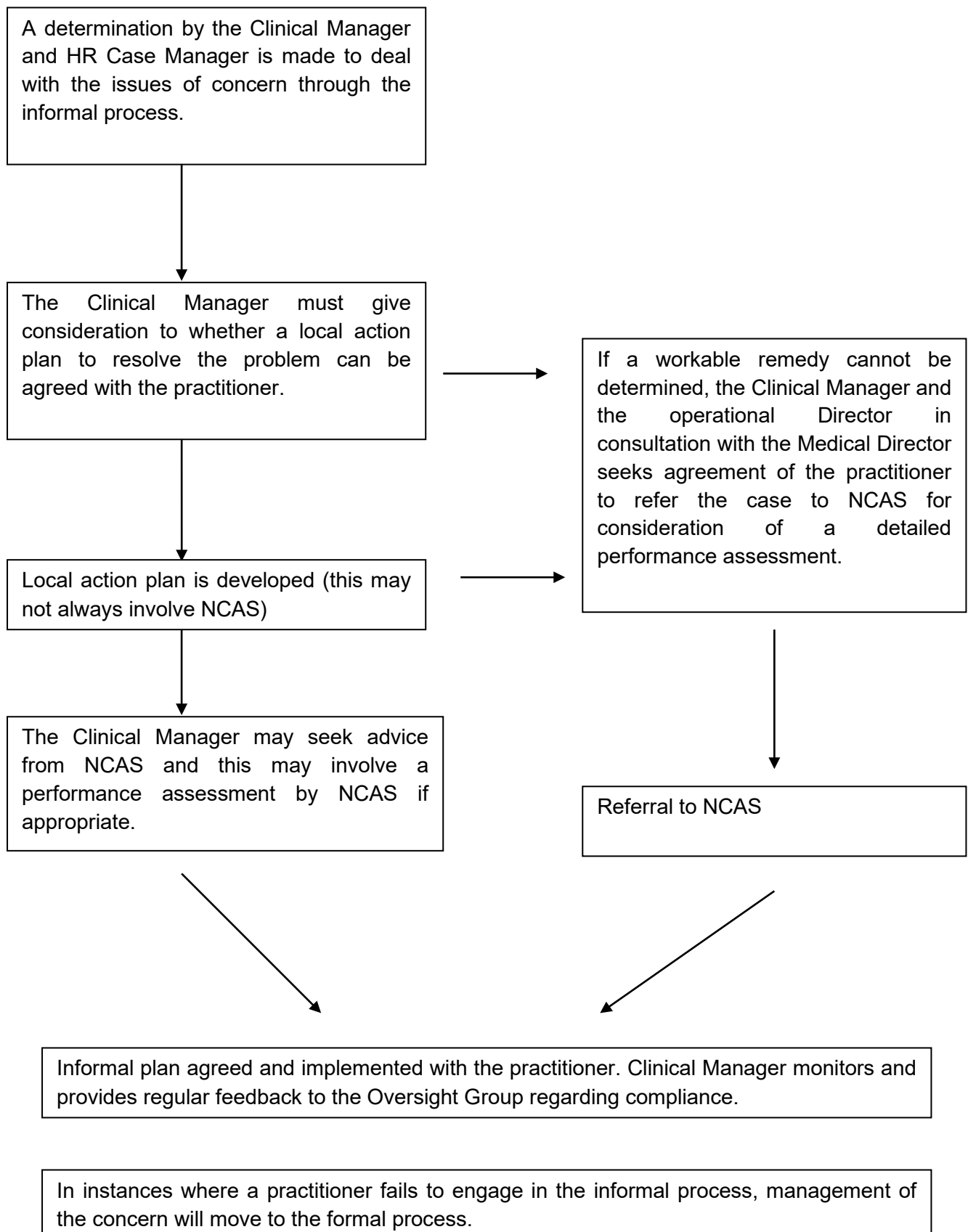
- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.
- 3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).
- 3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.
- 3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, 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 not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

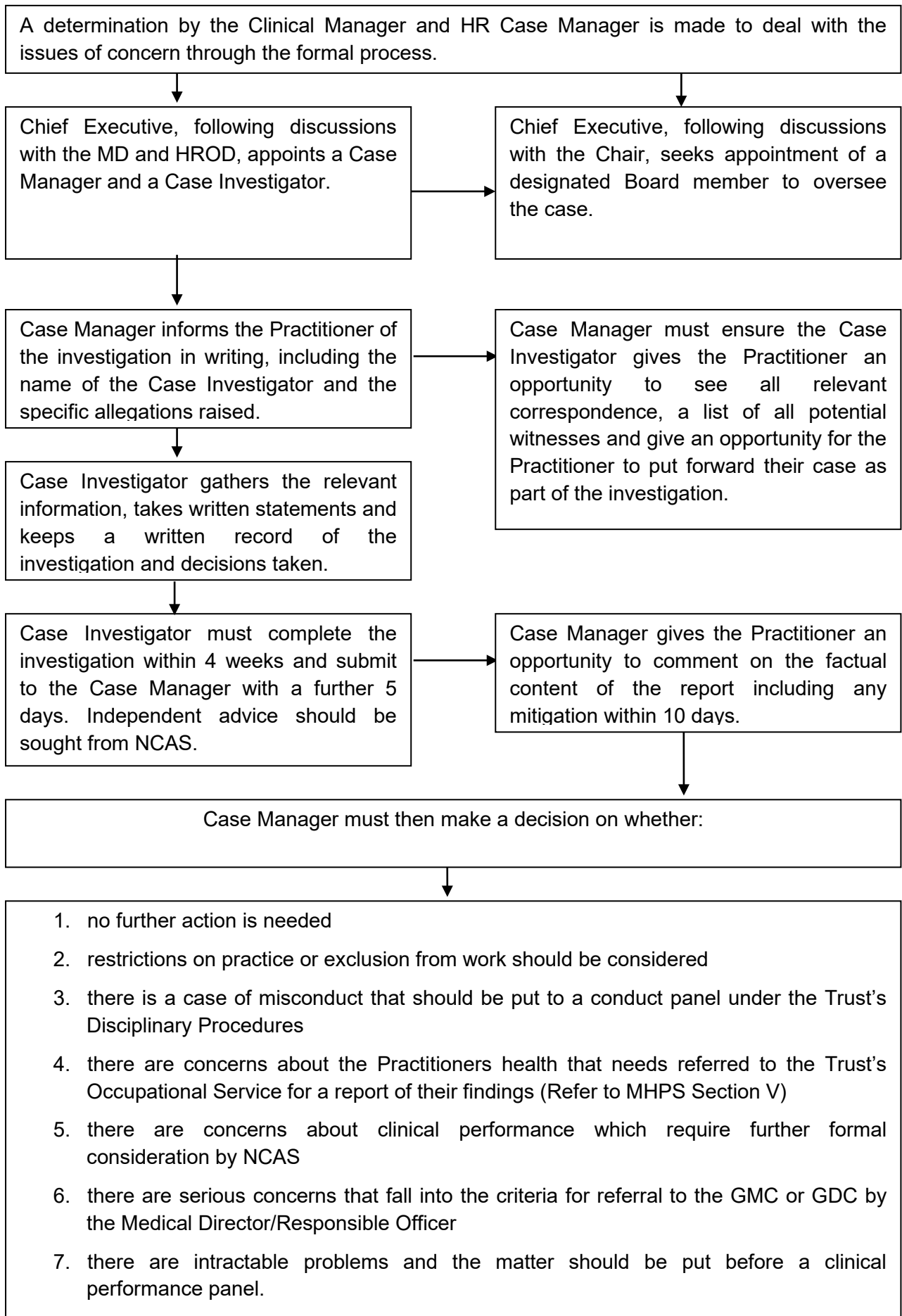
Step 1 Screening Process

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

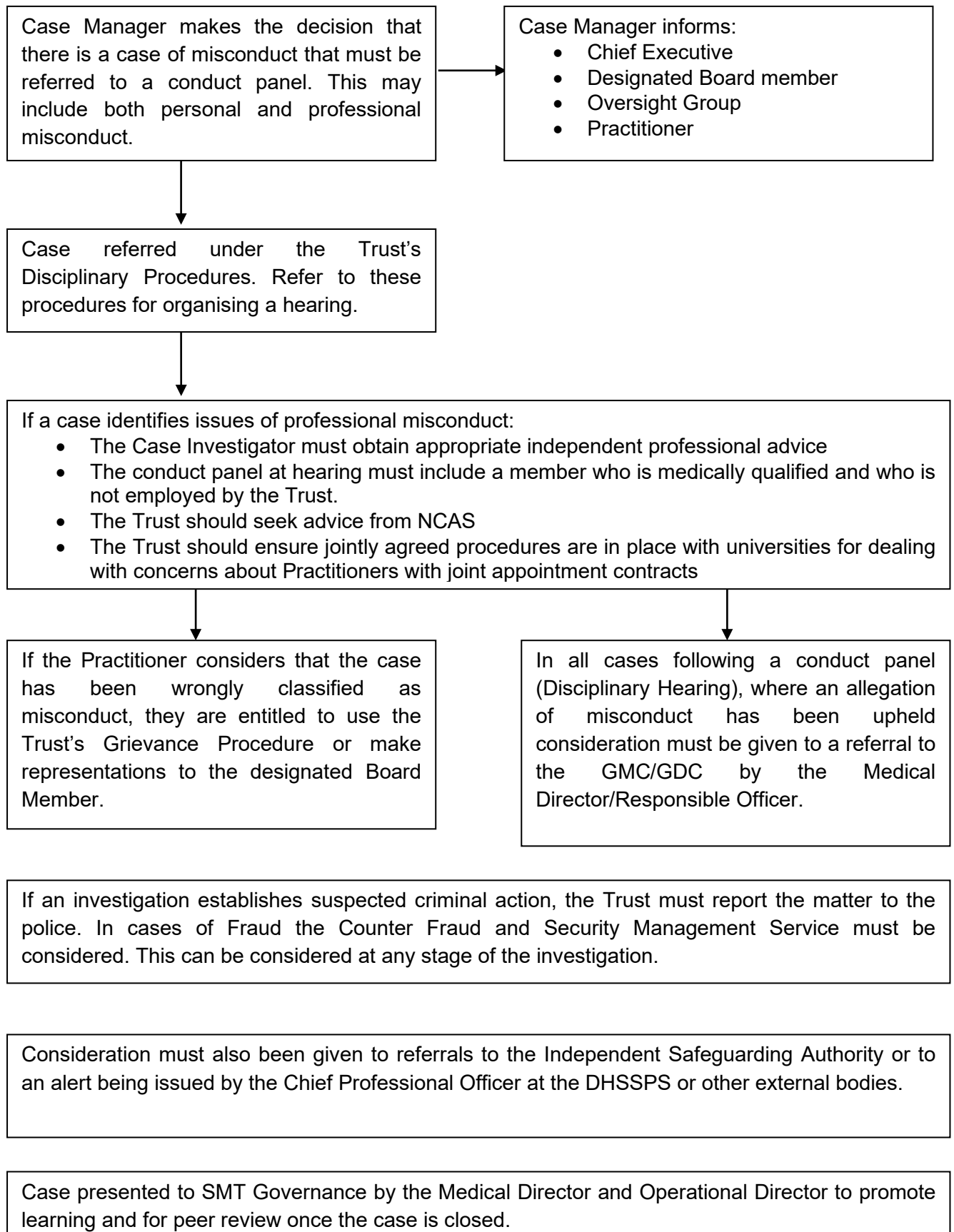
Appendix 1

Step 2 Informal Process

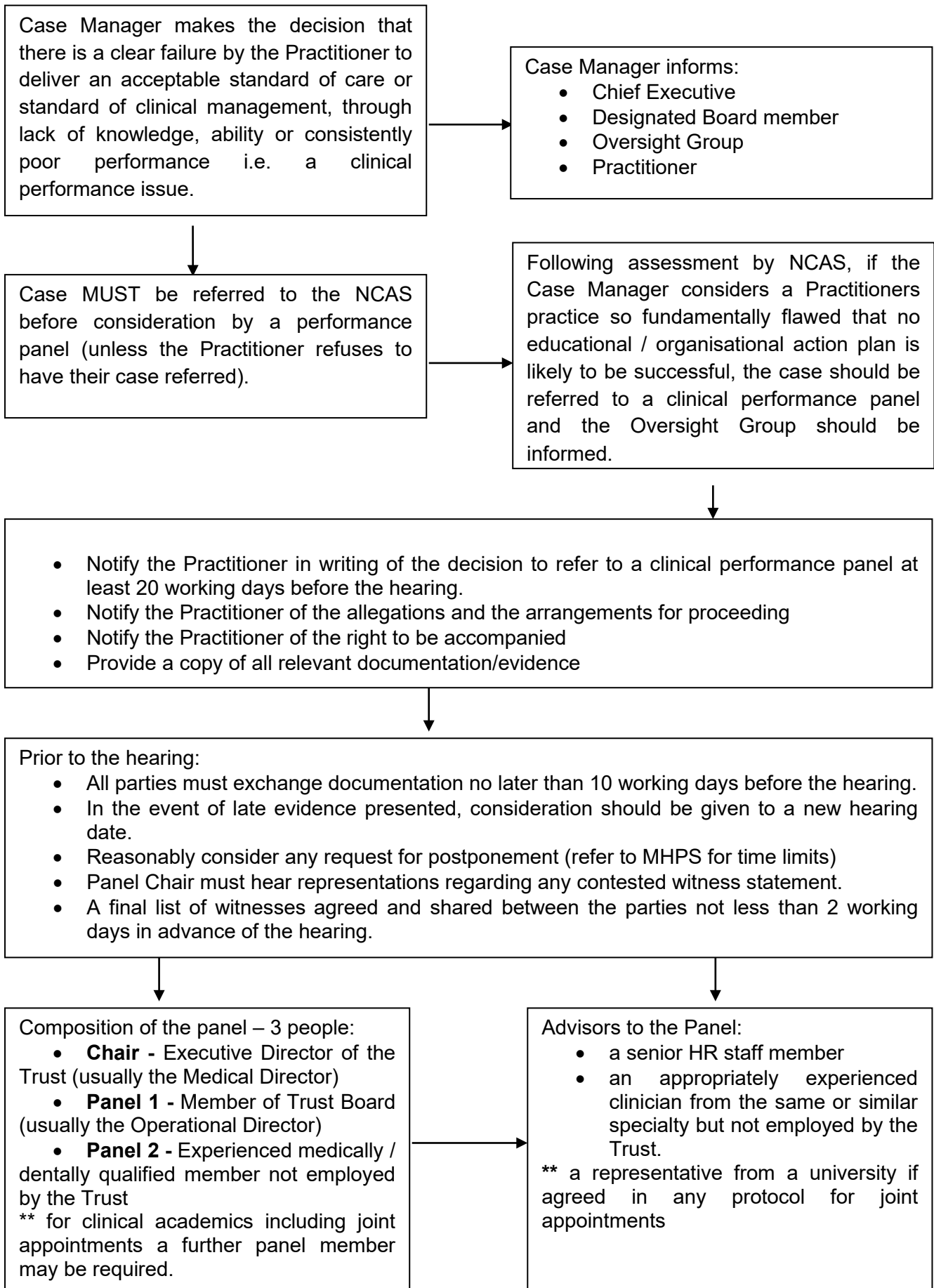
Appendix 2

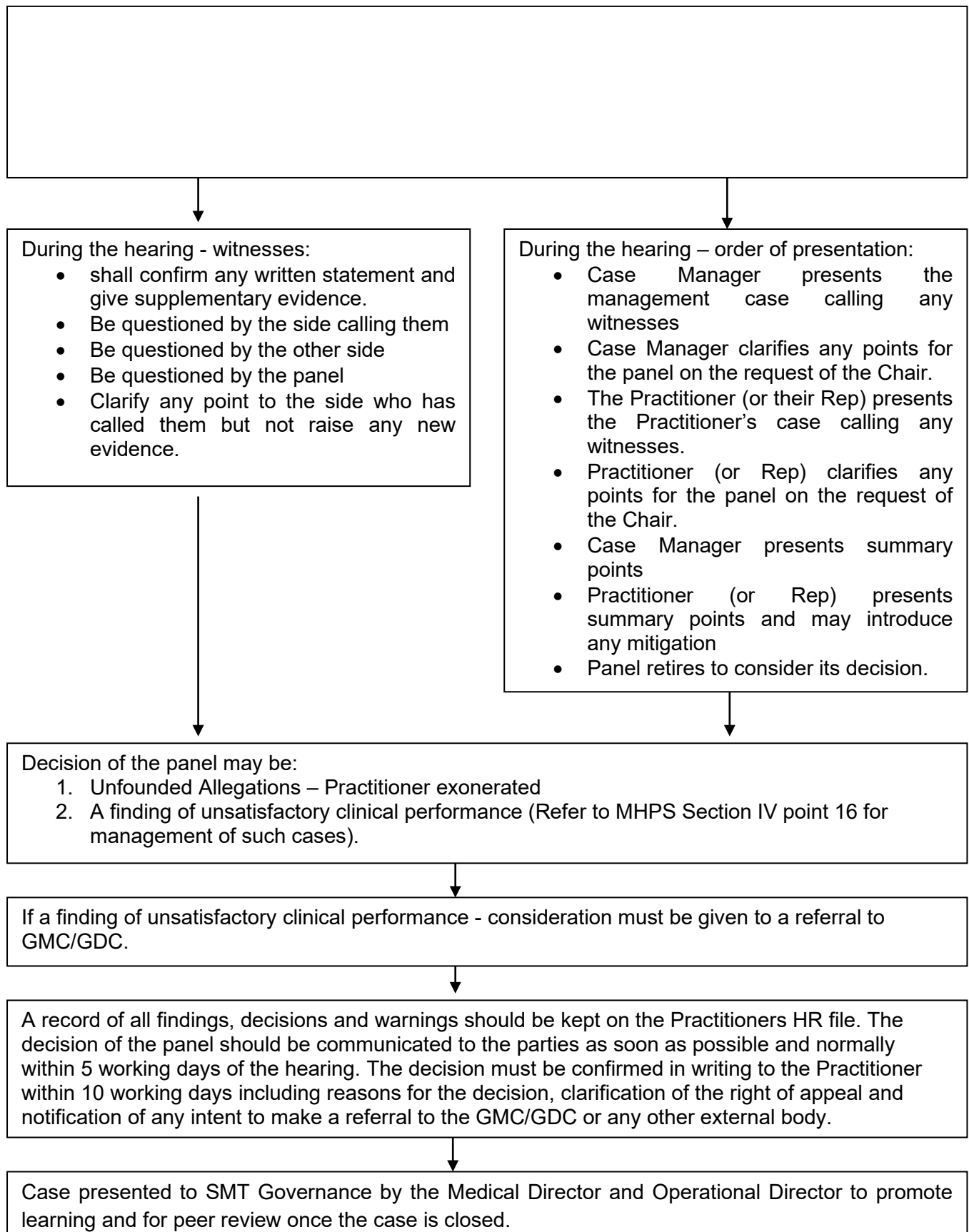
Formal Process

Appendix 3

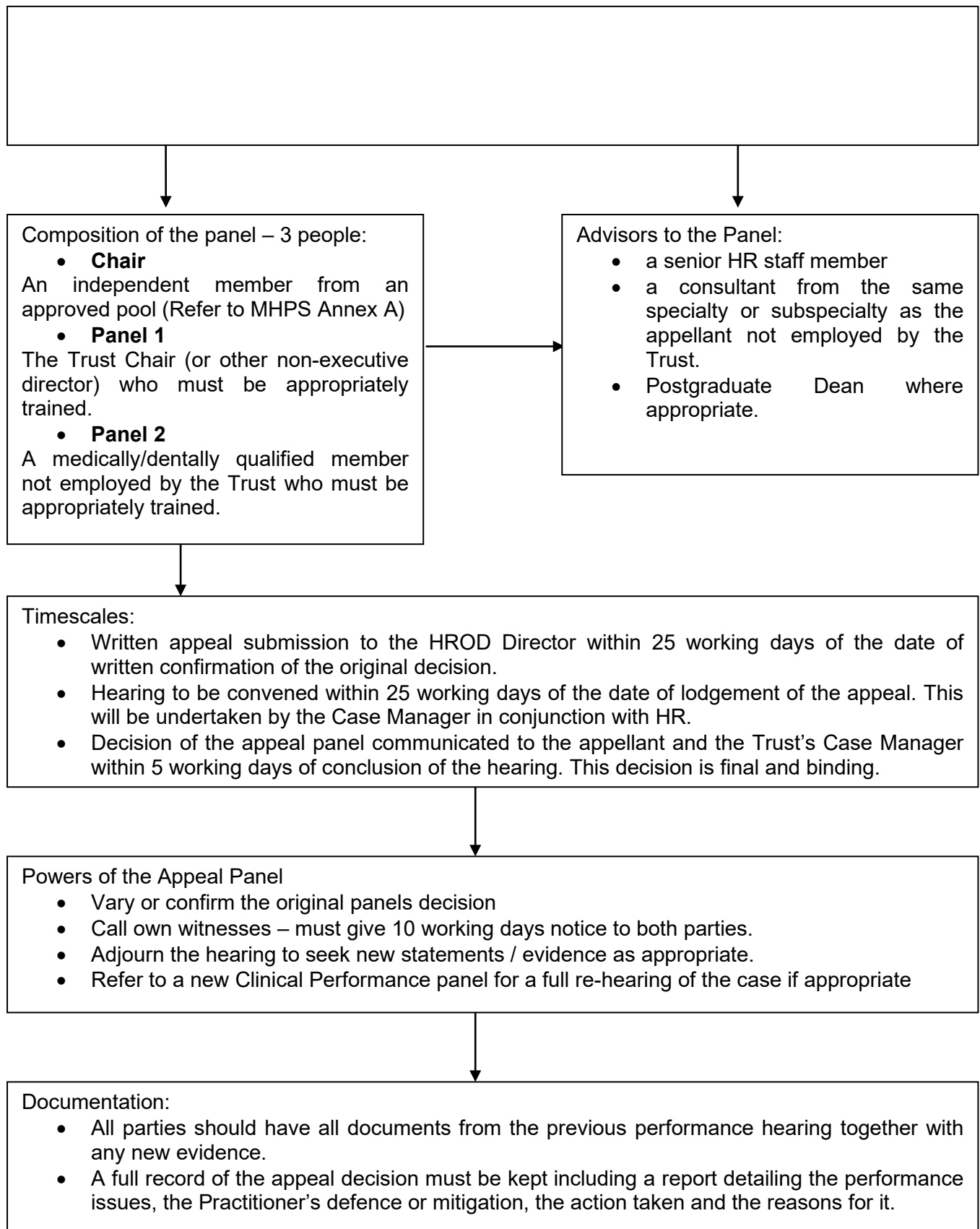
Conduct Hearings / Disciplinary Procedures

Appendix 3a

Clinical Performance Hearings

Clinical Performance Hearings

Appendix 4

Appeal Procedures in Clinical Performance Cases

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

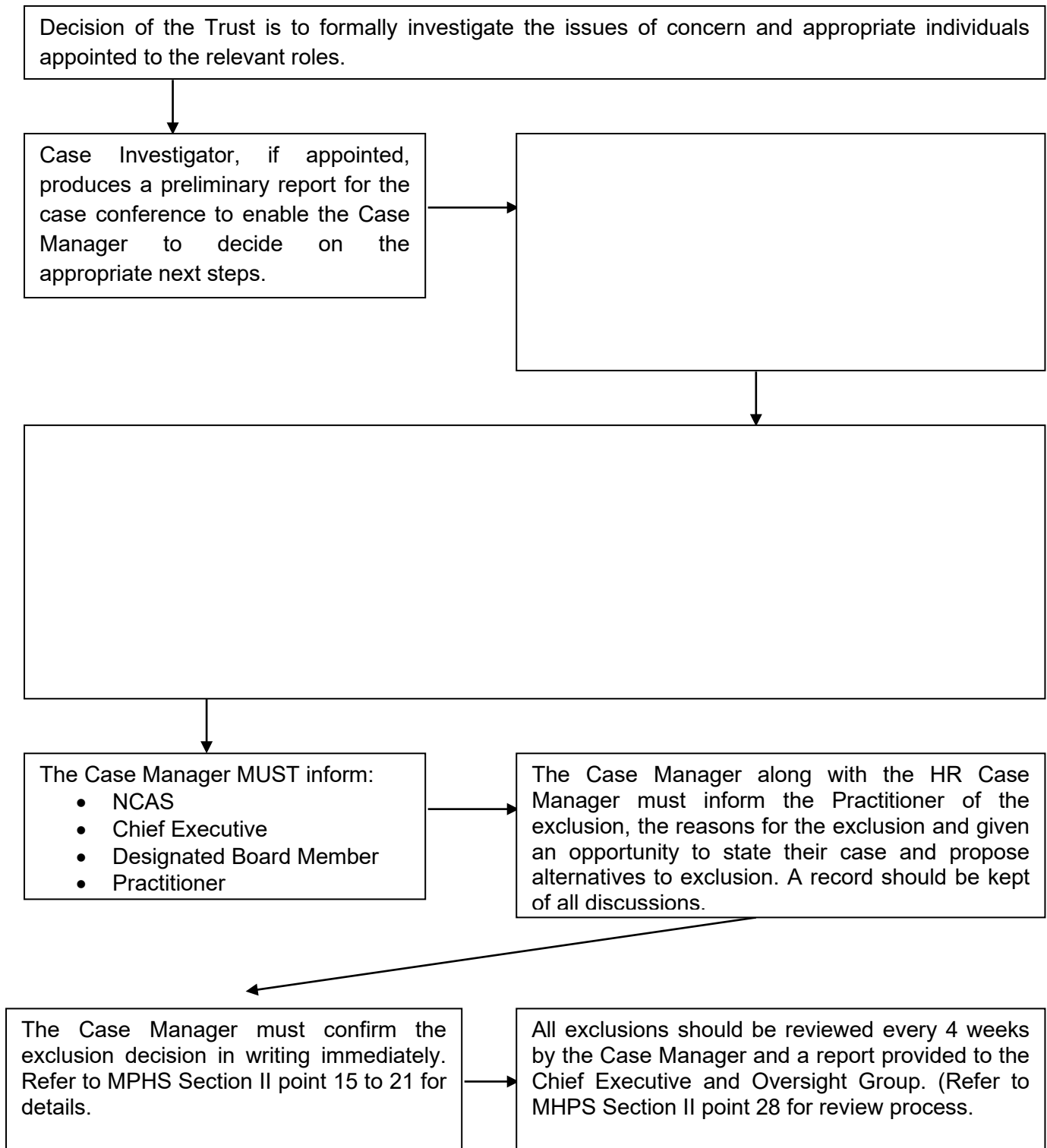
The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work**Formal Exclusion**

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.



Southern Health
and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

16 September 2010

1.0 Introduction

1.1 Maintaining High Professional Standards in the Modern HPSS *A framework for the handling of concerns about doctors and dentists in the HPSS*

(hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 The MHPS framework is in six sections and covers:

- I. Action when a concern first arises
- II. Restriction of practice and exclusion from work
- III. Conduct hearings and disciplinary procedures
- IV. Procedures for dealing with issues of clinical performance
- V. Handling concerns about a practitioner's health
- VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.
- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

- 1.5** This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.
- 1.6** This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.
- 1.7** This guidance should be read in conjunction with the following documents:

Annex A

“Maintaining High Professional Standards in the Modern NHS”
DHSSPS, 2005

Annex B

“How to conduct a local performance investigation” NCAS, 2010

Annex C

SHSCT Disciplinary Procedure

Annex D

SHSCT Clinical Manager’s MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1** NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

- 2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.
- 2.3 Concerns which may require management under the MHPS framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.
- 2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

- 2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expeditiously as possible and the Oversight Group will monitor progress.
- 2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.
- 2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.
- 2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

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A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

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An appeal panel can be invoked by the practitioner following a panel determination.

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Exclusion can be used at any stage of the process.

Appendix 6

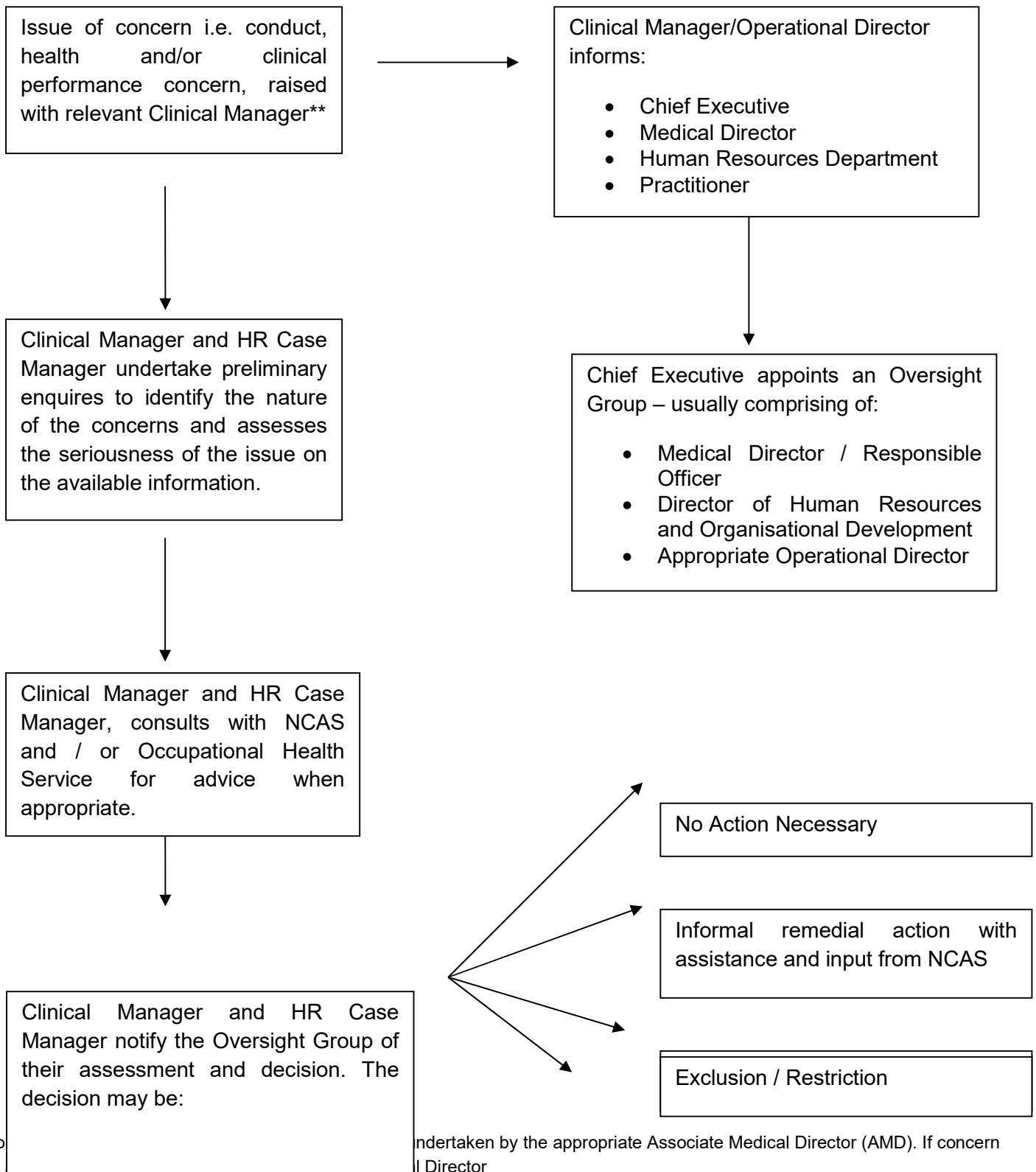
Role definitions

- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

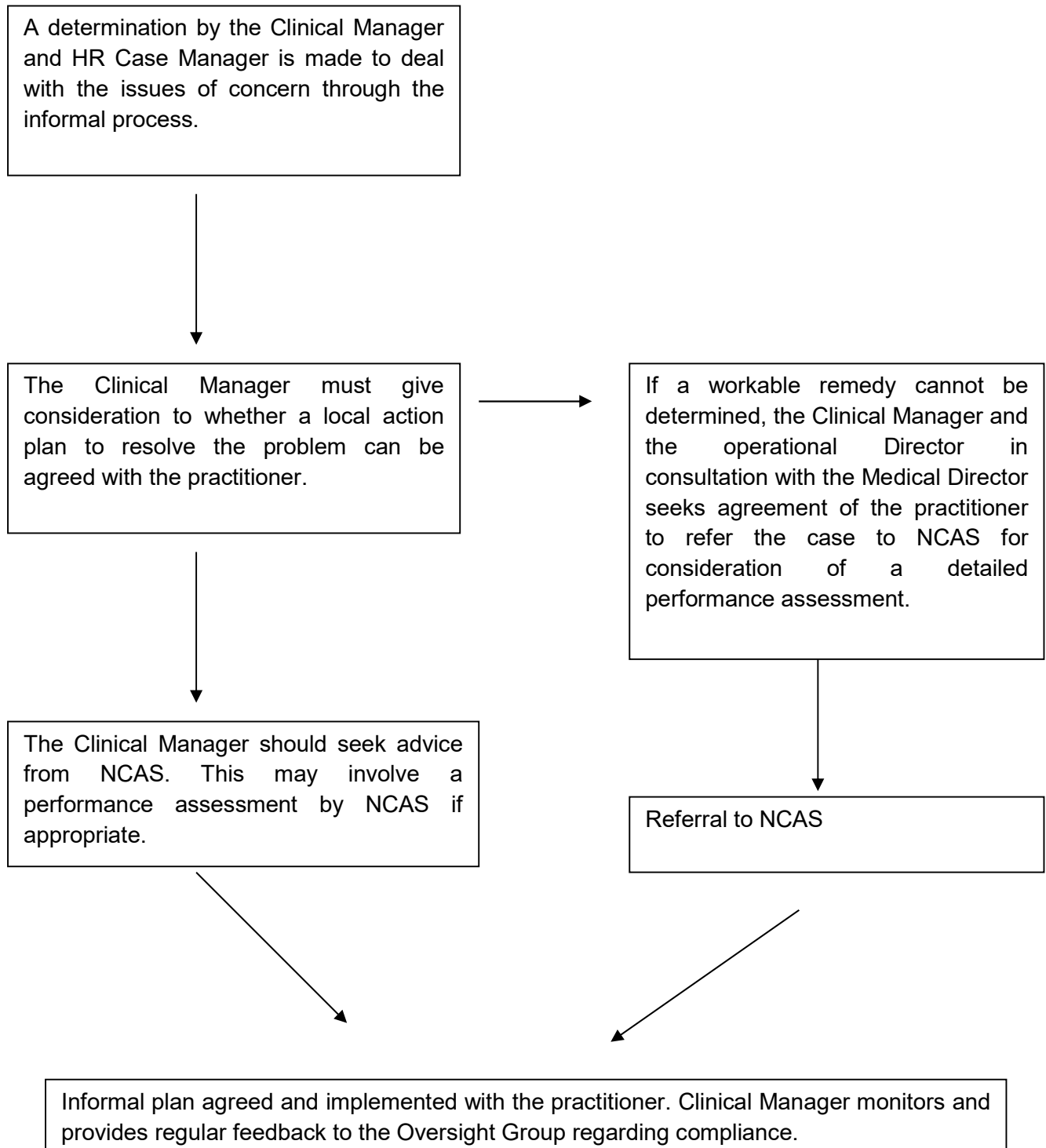
recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

- 3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).
- 3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.
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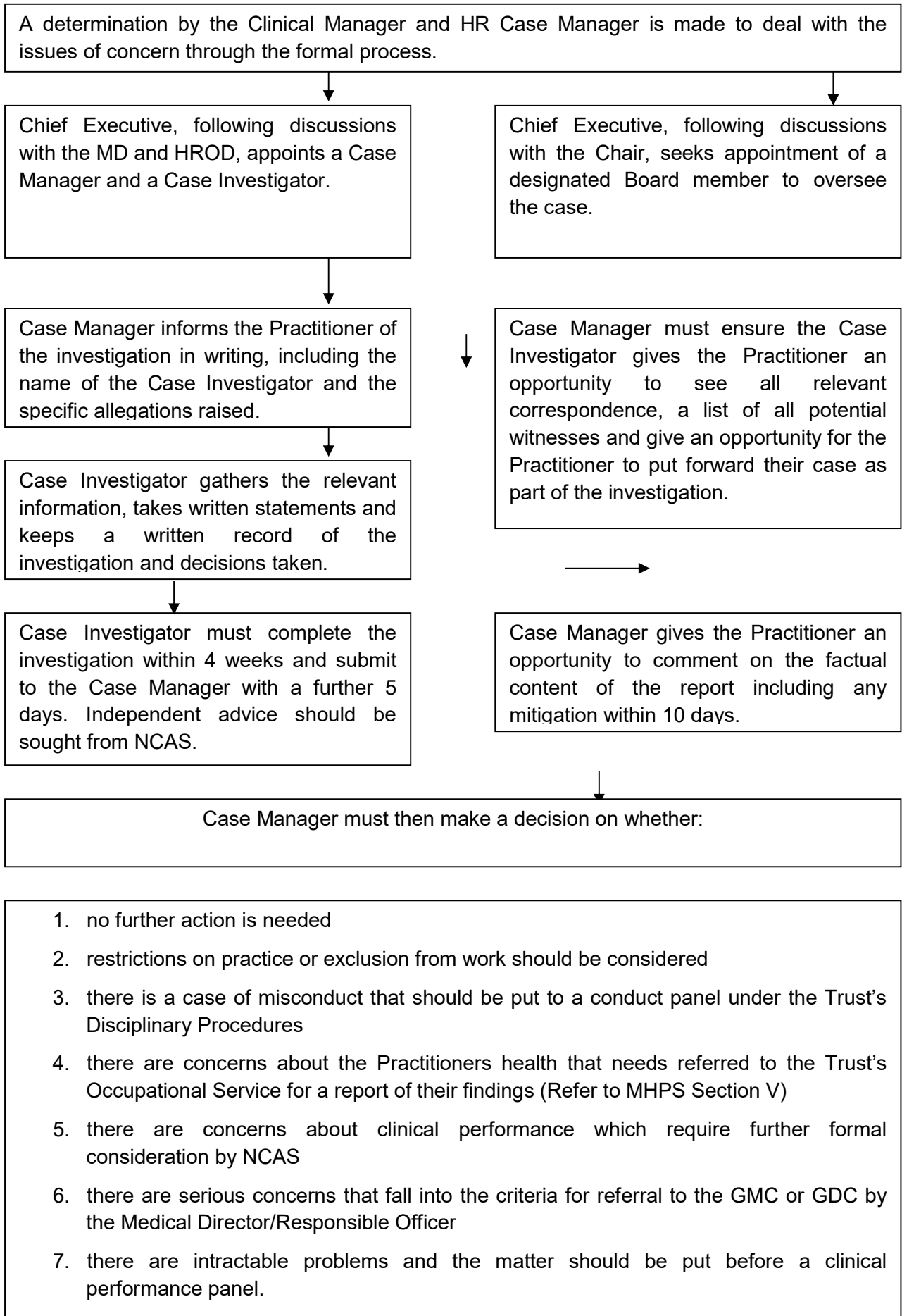
Appendix 1

Step 1 Screening Process

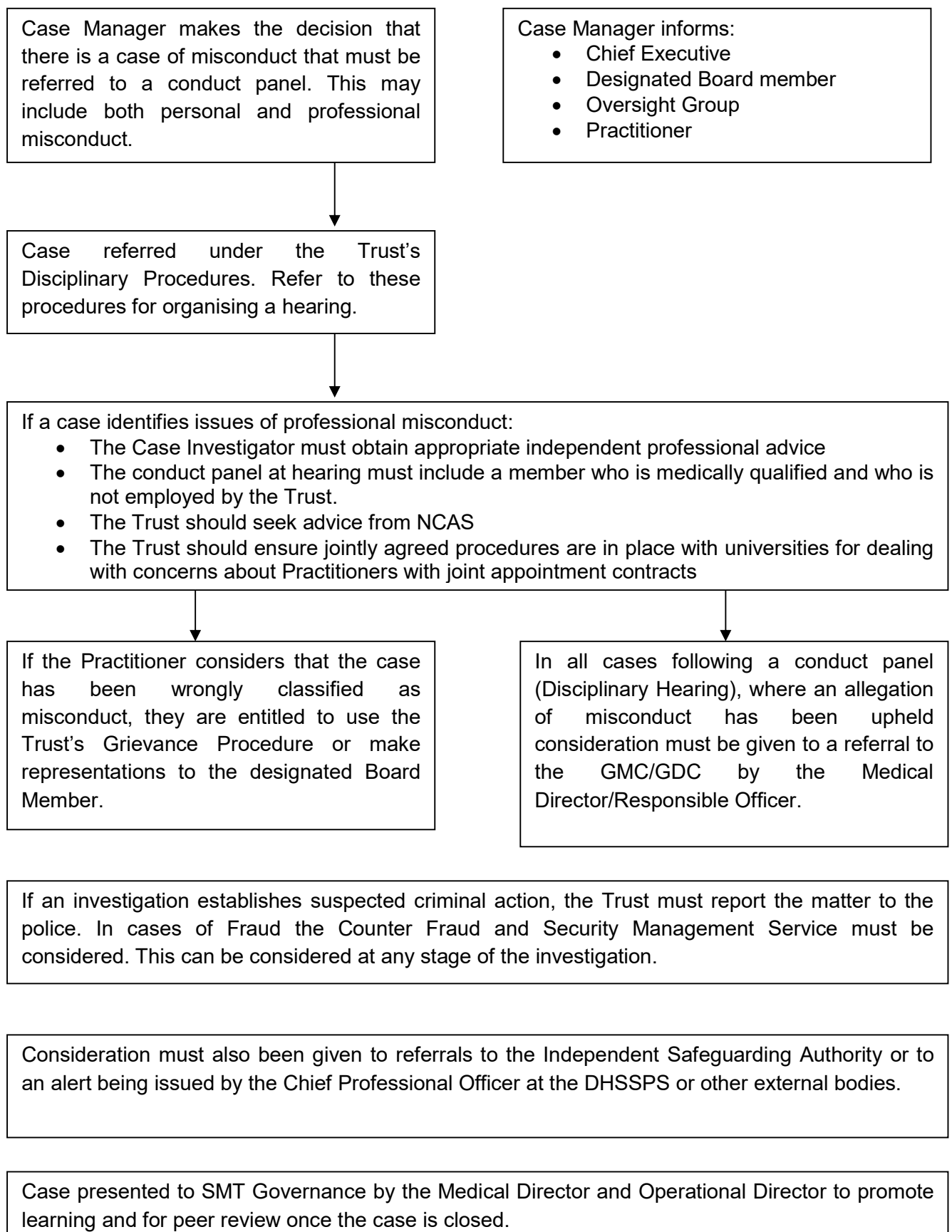
Appendix 1

Step 2 Informal Process

Appendix 2

Formal Process

Appendix 3

Conduct Hearings / Disciplinary Procedures

Appendix 3a

Clinical Performance Hearings

Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

Case Manager informs:

- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

Following assessment by NCAS, if the Case Manager considers a Practitioner's practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel and the Oversight Group should be informed.

Prior to the hearing the Case Manager must:

- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

Prior to the hearing:

- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

Composition of the panel – 3 people:

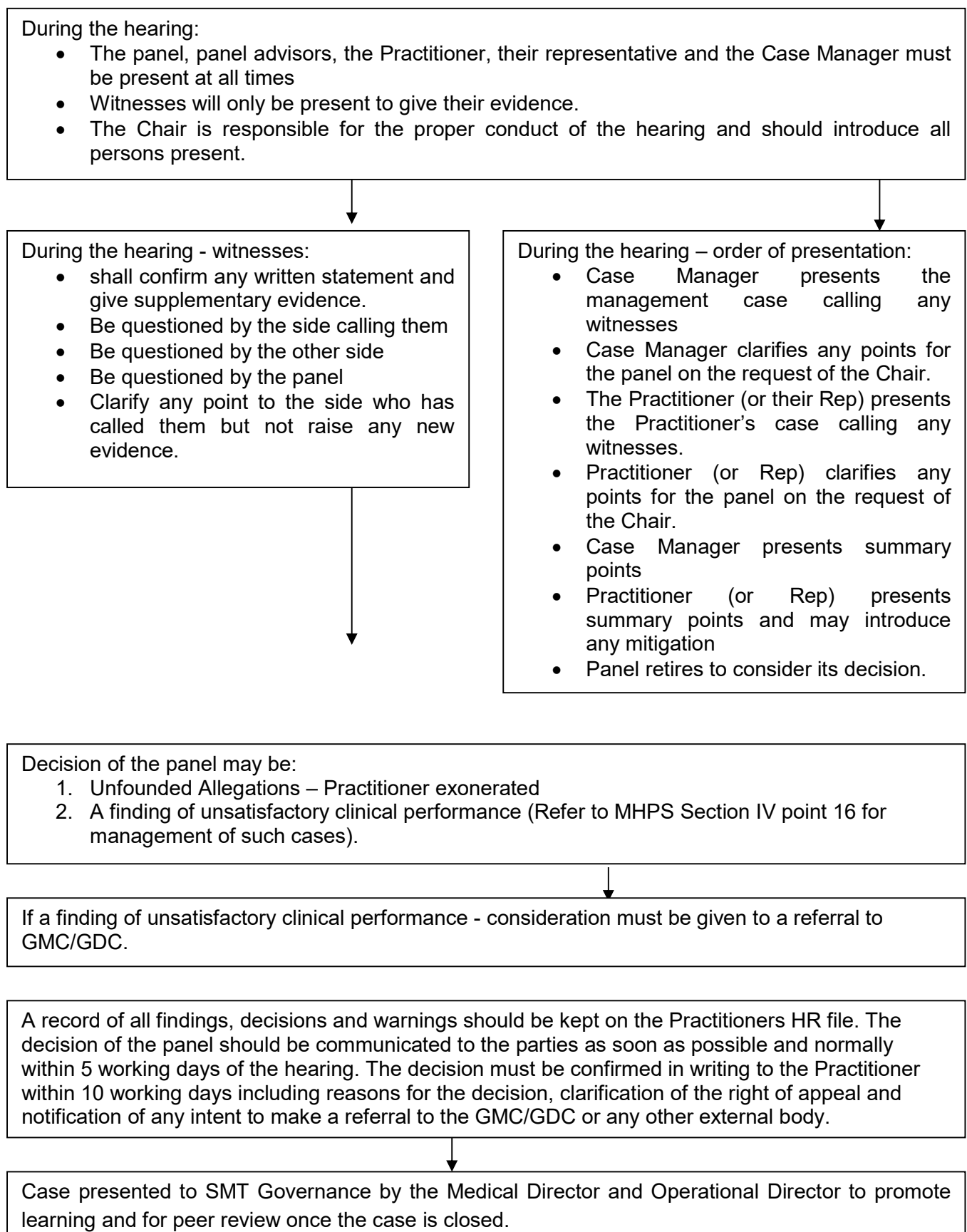
- **Chair** - Executive Director of the Trust (usually the Medical Director)
 - **Panel 1** - Member of Trust Board (usually the Operational Director)
 - **Panel 2** - Experienced medically / dentally qualified member not employed by the Trust
- ** for clinical academics including joint appointments a further panel member may be required.

Advisors to the Panel:

- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Appendix 3a

Clinical Performance Hearings

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
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The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

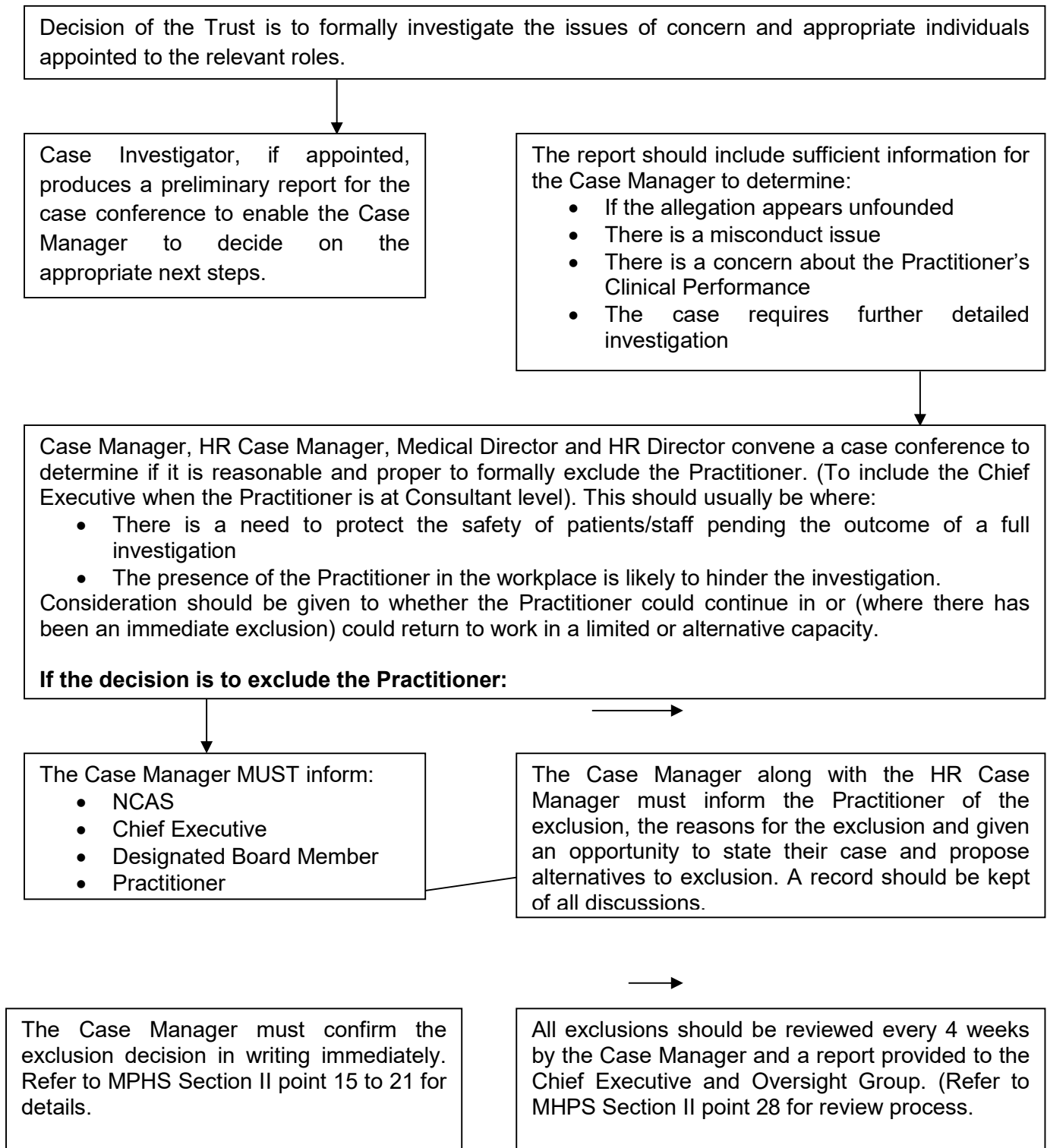
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- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work**Formal Exclusion**

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

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Chief Executive

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Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

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Case Manager

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Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

POLICY IN RELATION TO THE MANAGEMENT OF DOCTORS AND DENTISTS IN DIFFICULTY

1. Introduction

The policy has been written with a view to defining the procedures for dealing with doctors and dentists in the training grades who are experiencing difficulties within the Northern Ireland Deanery. The aims of the policy are to promote early identification of trainees in difficulty and provide a clear structure for identifying addressing these difficulties. It is based upon the principle of acting fairly, supportively and confidentially when dealing with problem situations that arise and draws and should be read in conjunction with the publication from the Department of Health, Social Services and Public Safety on '*Maintaining High Professional Standards in the Modern HPSS: A framework for the handling of concerns about doctors and dentists in the HPSS (DHSSPS 2005).*' This guidance provides the disciplinary framework for doctors and dentists in Health and Social Care and requires all HSC bodies to have procedures in place for handling serious concerns about an individual's conduct and capability that reflect this framework. The guidance covers restriction of practice and exclusion from work; conduct hearings and disciplinary matters and procedures for dealing with issues of capability.

It is the duty of all doctors to protect patients where it is believed that a doctor's conduct, performance or ill health constitutes a threat to patients. It is therefore the responsibility of the team with whom a trainee is working to highlight concerns before they become too severe and to enable the trainee to access the right help.

2. Roles and Responsibilities

A trainee has a contractual relationship with his or her employer and is subject to the policies established by the employing body. The employer has responsibility to ensure that employment issues, including performance, health and sickness issues and disciplinary matters are dealt with appropriately to facilitate the trainee's satisfactory performance.

The Northern Ireland Medical and Dental Training Agency (NIMDTA) has responsibility for commissioning education and training whilst the Trusts and other training providers have responsibility for delivering education. Training providers have a responsibility to ensure that mechanisms are in place to support trainees and enable problems to be addressed at an early stage.

The educational supervisor is the most likely person to be involved initially when a trainee is in difficulty although the Clinical Tutor, Clinical Director, Medical Director, GP trainer, Dental trainer and NIMDTA may also need to be informed depending on the nature and seriousness of individual circumstances. The roles and responsibilities of the various educators all of whom have a responsibility for dealing with doctors and dentists in difficulty are summarised in Appendix 1.

It is the responsibility of the training provider to investigate and manage concerns. Training providers must keep NIMDTA informed of all significant concerns and should inform the Postgraduate Dean in writing of any disciplinary action being taken against a trainee. The flow chart attached at Appendix 2 provides guidance on action which a training provider should take when problems arise.

If through investigation it appears that the problem relates to the trainer or the training post then the Postgraduate Dean must be informed in order that appropriate action may be taken and where necessary the training post inspected.

3. Identifying trainees in difficulty

All possible steps should be taken to identify and act on early signs and symptoms of difficulty. The majority of these are behavioural but also include signs of clinical incompetence, for example poor record-keeping; poor clinical decision making and judgement, inappropriate referrals etc.

Successful remediation or support for doctors and dentists in difficulty requires an understanding of the underlying problems. A checklist (Appendix 3) has been developed to help educational supervisors and others to diagnose and manage the early signs of a doctor in difficulty.

Concerns about a trainee's conduct or capability may come to light through:

- an untoward incident
- a complaint or litigation
- appraisal
- assessment
- performance data or clinical outcomes
- clinical audit

Clear evidence should be sought and concerns raised with the trainee at an early stage in order to obtain his or her perspective. The trainer should consult with colleagues to explore the nature and seriousness of the problem. As soon as it is clear that there is a problem with the trainee's conduct or performance action should be taken.

Managing potential risk to patients is the first priority and should be managed by the trainee and trainer/educational supervisor agreeing what the trainee can do safely and ensuring support and supervision from the whole clinical team to allow the trainee to practise safely in areas where he or she is underperforming.

Once the underlying cause of the trainee's difficulties is identified a realistic learning plan should be provided that will motivate and engage the trainee. If it is not possible

to deliver this in the trainee's current placement the trainee will need to be moved to a placement which will deliver the learning plan. The learning plan should be regularly reviewed throughout the course of its delivery to ensure that it continues to meet the trainee's needs. If the trainee continues to have difficulty, in spite of remedial action, advice should be sought from NIMDTA.

As a general principle good communication should be maintained at every stage with NIMDTA being informed as appropriate and as early as possible. The educational processes need to work closely with Trust internal procedures and close communication between the appropriate individuals within NIMDTA and those responsible at Trust level is crucial.

4. The Problems

These can be divided into four main areas as follows:

- Personal conduct
- Professional conduct
- Competence and performance issues
- Health and sickness issues

Personal Conduct Issues

Examples include intoxication, drug abuse, falsification of records, theft, fraud, serious acts of insubordination, sexual, racial or sectarian harassment, unlawful discrimination or victimisation. The employing authority will take the lead under its disciplinary procedures and will inform the Postgraduate Dean in writing at an early stage.

NIMDTA will not be involved in such a disciplinary panel but will need assurance of the following:

- The employing authority will follow an agreed disciplinary procedure
- The trainee has been advised that they may be represented at any stage of the disciplinary procedure by the BMA/BDA, or work colleague
- National guidelines are followed if a trainee is to be suspended
- Pastoral support is provided if required

On occasions it may be necessary for the Trust/Postgraduate Dean to advise the General Medical Council/General Dental Council of any action taken against a trainee.

Professional Conduct Issues

Examples include research misconduct, failure to obtain consent properly, prescribing issues, improper relationships with patients, improper certification issues (eg the signing of cremation forms, sickness certification) and breach of confidentiality. The Trust or other employer will take the lead under its disciplinary procedures and will inform the Postgraduate Dean in writing at an early stage. An agent of NIMDTA eg Head of School, GP Trainer, Programme Director or Dental Adviser will provide input into such a disciplinary process. Any decision to involve the GMC/GDC will be taken jointly by the employing authority and NIMDTA. NIMDTA will need to be assured that:

- The employing authority will follow an agreed disciplinary procedure
- The trainee has been advised that they may be legally represented eg by the BMA/BDA, a work colleague
- National guidelines are followed if a trainee is to be suspended
- Pastoral support is provided if required

Competence and Performance Issues

Examples include a single serious mistake, poor results clinically (possibly found as a result of audit), poor communication skills, poor consultation skills and repeated failure to attend educational events.

Trainees with such problems will need to be referred by the educational supervisor to the Programme Director and Head of School in the first instance although the Trust or other employer may need to take a lead in some of these problems if there has been a complaint from patients or relatives and the possibility of legal action.

In the event of an isolated serious mistake the Postgraduate Dean must be informed in writing and at each stage in any process that results from such a mistake. Pastoral support must be offered and the doctor/dentist advised to seek legal representation.

If the doctor's/dentist's performance is consistently poor, despite educational measures such as remedial or targeted training, then it may be necessary to inform the GMC/GDC. Any decision taken will be agreed jointly by the employing authority/employer and NIMDTA.

It is accepted that Trusts and other employers have an over-riding duty to protect patients and NHS staff, and exceptionally an employer may need to invoke its policies and procedures to expedite a critical situation. NIMDTA should be kept informed of any such action.

Health and Sickness Issues

Every doctor/dentist must be encouraged to register with a local general medical practitioner and consult with their doctor in the first instance when ill.

'If you know that you have a serious condition that you could pass on to patients, or that your judgement or performance could be significantly affected by a condition or illness or its treatment, you must take and follow advice from a consultant in occupational medicine or other suitably qualified colleague on whether and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients'.

Ill health and sickness absence should be managed through the employer's sickness absence policies. Where sickness absence gives cause for concern the trainee should be referred to the Occupational Health service and information shared with the educational supervisor, Clinical Tutor, Medical and HR Directors on a confidential basis, with the consent of the individual concerned. NIMDTA should also be informed

in writing of such cases and where the trainee's fitness to practise is called into question the employing authority should make a referral to the GMC or GDC as appropriate. Advice from either body may be sought in advance of referral.

Periods of grace due to sickness absence before training may be affected are as follows:

- Foundation 1 doctor – 4 weeks in the year
- Foundation 2 doctor – 4 weeks in the year
- GP Trainee – 2 weeks in a 12 month post
- Specialty Registrar – 3 months in the training programme before CCT date affected

6. Keeping Records

Documentation should commence as soon as a performance concern comes to light and copies given to the trainee. Whilst only a small minority of performance difficulties escalate into a disciplinary situation, records should nevertheless be kept from the earliest stage to help ensure continuity (e.g. a trainee who changes educational supervisor) and to avoid duplication of effort. Good documentation is an essential part of educational governance.

Should a problem with a doctor become more serious or repetitious, it may be advisable to seek guidance from the local HR Manager or Director who can advise on any further specific documentation.

Trainees need to have confidence that this documentation is intended to support and help them to address their difficulties rather than as a punitive or legalistic activity. Transparency is paramount to retain the doctor's trust and cooperation. The following will help to ensure openness as well as rigour:

- Educators should avoid recording and keeping information about discussions with doctors without their knowledge or consent.
- Records of conversations should be held confidentially, with the doctor's knowledge and consent, by the person who has conducted the assessment of the problem with the doctor in difficulty.
- The doctor should be given a copy of any documentation concerning his or her performance and encouraged to keep such copies in his or her portfolio for discussion at appraisals.
- Should the doctor move to a different job, or in the event that the problem escalates or others become involved, it may become necessary to pass the record to other parties, again with the consent of the doctor where possible. Transfer of information about trainee doctors' progress from post to post should become standard procedure including areas of concern.
- All documentation must comply with the requirements of the Data Protection Act and the Freedom of Information Act (FOIA).

5. Transfer of information to Future Training Providers

The educational supervisor in the next placement must be informed of problems arising in the previous placement to ensure that any remedial action that has been taken continues and assessment of successful progress is made. In Dental postgraduate training the relevant Dental Advisers should ensure the transfer of information from one post to another is complete.

In instances where disciplinary issues or serious competence issues are involved a written statement must be given to the Postgraduate Dean to pass on to the new employing authority, on a need to know basis, with the knowledge of the doctor/dentist concerned. The doctor/dentist will have the right to see such a statement and challenge its accuracy, but not to prevent it being transferred to the new employing authority.

Information should be accurately recorded with a clear account of the issue, the action taken and the date when any disciplinary action is considered to be spent.

Details of special educational needs are best transferred via the Postgraduate Dean to the receiving educational supervisor.

Where a doctor/dentist becomes ill during the training it is important that consistent support is provided which can be transferred across training placements. There should be one source of referral to Occupational Health for doctors and dentists appointed to training programmes/posts. Unless there are ethical barriers to doing so, information should be shared by the Postgraduate Dean across employers, on a need to know basis.

6. Assessment and Appraisal

Regular appraisal and assessments are essential to provide feedback on performance and continuing progress and identify educational and development needs. It is important that Deanery standards are adhered to. Appraisals and assessments must be documented and copies retained.

APPENDIX 1: Roles and Responsibilities of Educators

- 1) Clinical Supervisors
- 2) Educational Supervisors
- Lead Educators

Specialty

- 3) College Tutor
- 4) Programme Director
- 5) Head of School
- 6) Regional Adviser

Trust

- 7) DME/Clinical Tutor
- 8) FP Director

- 9) Associate Postgraduate Dean
- 10) Postgraduate Dean
- 11) Director of GP Education
- 12) Postgraduate Dental Dean

1) Clinical Supervisor

Consultant with whom the doctor works clinically, and who assesses whether that doctor is safe to carry out the clinical work he/she is expected to do within the department, and that he/she progresses within the particular training post/module. This will include direct input to workplace-based assessment.

Responsibility for Doctors in Difficulty

This direct contact with the doctor puts the clinical supervisor in an ideal position

- to detect problems with regard to clinical knowledge and skills, team working, communication, attitude, time keeping, etc.
- Any problems observed should be documented, discussed with the trainee and brought to the attention of their educational supervisor.
- Trust policies and procedures should be followed as appropriate.

2) Educational Supervisor

Responsible for ensuring overall progress of the doctor through training. Includes responsibility for regular appraisals, collation of workplace-based assessment outcomes and the provision of career advice and support as required.

Responsibility for Doctors in Difficulty

- Should be made aware of and gather evidence about concerns from other team members.

- Should discuss these concerns with the doctor during regular appraisals and consider ways of addressing them, with the help of the multi-disciplinary team.
- If problems cannot be resolved within educational supervision context, or in current post, Educational Supervisor needs to access help from either within the Trust (Foundation Programme Director or Clinical Tutor) or within the Specialty (College Tutor or Programme Director), depending on the grade of the doctor and the nature of the problem (i.e. health, capability or conduct).
- Careful documentation is crucial at all stages.

3) College Tutor

Appointed by Specialty College but based in the Trust and responsible for advising and supporting doctors within a particular specialty in a Trust.

Mostly responsible for ensuring that trainees and supervisors adhere to College standards with regard to local educational programmes, regular appraisals and assessment, logbooks/portfolios in that particular specialty.

Responsibility for Doctors in Difficulty

- Career advice about their specialty
- Advice on exam procedure and requirements e.g. for doctors repeatedly failing exams
- Advice on specialty-specific issues
- Support for Educational Supervisors

4) Programme Director

Appointed by Deanery to manage specialty training programmes at Deanery level within a given specialty.

Responsible for allocation of specialty trainees to posts, supervision of individual training programmes, regular formal assessment including RITA/ARCP process, problem solving and feedback on progress.

Responsibility for Doctors in Difficulty

- Support trainees within their programme and deal with individual issues
- Support Educational Supervisors within their programme and provide advice on issues with individual doctors
- Identify issues at annual RITA/ARCP review
- Ensure that Doctors in Difficulty Strategy is implemented
- Resolve issues within programme (e.g. by moving individual doctor to different post/supervisor) wherever possible
- Bring more serious problems to attention of Trust (e.g. if patient safety at risk) or Deanery (e.g. if implications for training programme and additional resources required)

5) Head of Specialty School

Oversees, on behalf of the Deanery the activity and proper functioning of the Specialty School; liaises with the relevant College, Faculty or SAC; and supports the Programme Directors.

Responsibility for Doctors in Difficulty

No direct responsibility but can act as general source of advice for specialty and may decide to bring a particular problem to the attention of the Specialty School, to raise awareness and learn from the case.

6) Regional/Specialty Adviser

Appointed by College in consultation with Deanery/Institute; provides link between College and Deanery on education and training in the specialty.

Responsibility for Doctors in Difficulty

General support to doctors in difficulty and those who have to deal with them, particularly when advice is required on mandatory requirements of training.

7) Clinical Tutor/Director of Medical Education

Appointed by Postgraduate Dean together with Trust; manages the educational contract between Deanery and Trust and provides main link between the Postgraduate Dean and individual Trust with regard to training and education of doctors in all grades within a particular Trust.

Responsibility for Doctors in Difficulty

- Should be made aware of all issues with individual doctors in training in the Trust
- Should provide advice and guidance to trainees, clinical and educational supervisors on matters relating to health, capability and conduct
- Should monitor and inform the Deanery on progress of doctors in difficulty
- Should work closely with Human Resources Department on issues regarding doctors in difficulty, especially where patient safety may be compromised
- Should refer to Deanery those problems that cannot be resolved within the Trust
- Should involve Human Resources Department and invoke Trust procedures as required

8) Foundation Programme Director

As above but with particular responsibility for Foundation trainees. Needs to work closely with the Clinical Tutor/Director of Medical Education and Associate Dean for Foundation Training on all issues regarding Foundation trainees.

9) Associate Postgraduate Dean (Career and Personal Development)

Associate Dean with specific responsibility for doctors in difficulty provides strategic lead and direct support to educators on matters concerning doctors in difficulty, on behalf of the Postgraduate Dean.

Responsibility for Doctors in Difficulty

- Develop, manage and inform on framework for dealing with doctors in difficulty
- Ensure that resources are available to support the framework including remedial training, referral to NCAS, etc.
- Ensure that those dealing with doctors in difficulty are appropriately trained and supported
- Provide advice to educators on individual doctors in difficulty
- Assess and support those doctors in difficulty who require specialist input at Deanery level

10) Postgraduate Dean

Overall responsibility for postgraduate training and education within a geographical area.

Responsibility for Doctors in Difficulty

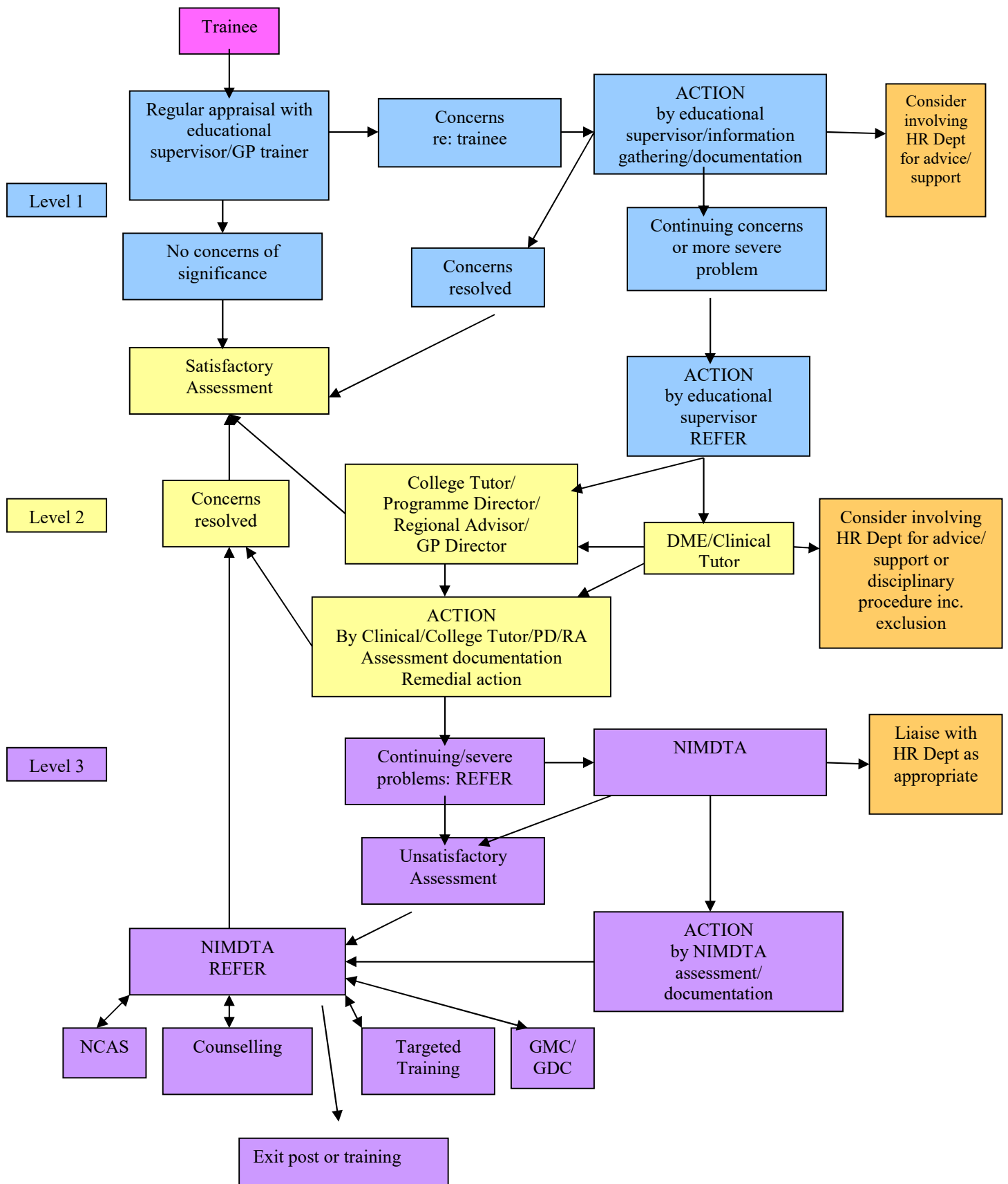
- Support and advice to Associate Dean dealing with doctors in difficulty
- Provide direct input to those cases where training may need to be terminated, or where appeals procedures need to be invoked

11) Director of GP Education

As for Associate Dean/Postgraduate Dean but with sole responsibility for trainees in General Practice.

12) Postgraduate Dental Dean

As for Associate Dean/Postgraduate Dean but with sole responsibility for trainees in Dentistry.

APPENDIX 2**Trainees in difficulty – Process Flowchart**

Level 1

The aim of Level 1 is to identify trainees in difficulty as early as possible in order to avoid difficult situations where problems have developed to such an extent that their solution requires major intervention. Regular appraisal and assessment of a trainee's performance by educational supervisors is an important opportunity to identify and deal with the majority of problems within the trainee's current educational setting.

Where concerns are identified by a supervisor these should be discussed openly with the trainee and further information gathered from other members of the team.

Level 2

In certain situations e.g. major clinical incident the most appropriate course of action will be to follow the disciplinary procedures of the trust (in accordance with the 'Maintaining High Professional Standards' framework). However the Director of Medical Education/Clinical Tutor and NIMDTA should be informed that such an action has been undertaken.

More commonly the next step would be to involve the clinical tutor (see Appendix 1). Depending on local circumstances or whether the problems may have implications for progress in training for that trainee it may also be appropriate to seek the advice of the college tutor, specialty training programme director and /or regional advisor. For General Practice trainees the most appropriate contact may be the Director of GP Education and for Dental trainees the Postgraduate Dental Dean.

Many problems will be resolved by local intervention by the Director of Medical Education or Clinical Tutor, with the support of the college tutor etc. This will include assessment of need, further documentation and where appropriate remedial action with the support of the local consultant(s)/educational supervisor(s) and their team(s).

Level 3

This level of intervention will be required for a minority of trainees in difficulty who have been identified by DMEs/Clinical Tutors and or training programme directors as having difficulties which either have not been resolved by local intervention, or which require further input which is not available locally.

All trainees fulfilling these criteria should be referred to NIMDTA who will undertake further assessment of the needs of the particular trainee.

Where appropriate the trainee can be referred for support and counselling and/or arrangements can be made for targeted training with a selected educational supervisor.

Such interventions will have resource implications. Not all trainees will wish to move through this formal process and individual solutions to trainees' problems at local level may and should still be encouraged.

All attempts at targeted training will need to be recorded and monitored with clear indications of how progress has been assessed. Such systems as are agreed and planned for implementation may need to be discussed with Chief Executives, Medical Directors and Clinical Tutors. This is not just a matter of courtesy but to ensure that the systems link into Trust based systems for clinical risk management and clinical governance.

Where a concern about a doctor's or dentist's performance arises and the employer feels it needs help, the GMC (or GDC) and NCAS may be approached.

- If the concern, whether of performance, health or conduct, is so serious as to call into question the doctor or dentist's licence to practice, then the regulator's (**GMC/GDC**) advice should be taken. This approach will therefore only be used in the most serious circumstances.
- In all other circumstances, such as immediate concerns that might require exclusion or suspension, general concern about a practitioner's performance, conduct or competence, and in any situation where the local organisation is unsure how to proceed, **NCAS** should be contacted

APPENDIX 3**Checklist for educational supervisors: how to diagnose and manage a trainee in difficulty****Symptoms and Signs**

Is your trainee demonstrating any of the following?

Anger; rigidity/obsessive behaviour; emotionality; absenteeism; failure to answer bleeps; poor time keeping or personal organisation; poor record-keeping; change of physical appearance; lack of insight; lack of judgement; clinical mistakes; failing exams; discussing a career change; communication problems with patients, relatives, colleagues or staff?

Have there been complaints from patients or staff about any of the following?

Bullying; arrogance; rudeness; lack of team working (e.g. isolation; unwilling to cover for colleagues; undermining other colleagues; criticising or arguing in public/in front of patients); defensive reactions to feedback; verbal or physical aggression; erratic or volatile behaviour

Underlying reasons/explanations

Can you identify any reasons for the above signs and symptoms – for example?

Poor approach to studying; lack of knowledge; lack of skills; lack of confidence; deficient interpersonal skills; language barrier; attitudinal /personality problem; stress due to life events; stress due to work (e.g. dysfunction in the team; problems with trainer/supervisor or the training process; a specific critical incident affecting confidence); poor motivation; health problems; drug or alcohol abuse; physical illness; psychiatric illness; workload; sleep deprivation.

Is the problem due to any of the following factors within the individual?

Capacity – a fundamental limitation that will prevent them from being able to do their job (e.g. mental or physical impairment). If so, then a change of role or job may need to be considered.

Learning – a skills deficit through lack of training or education. In these cases, skills-based education is likely to be appropriate, provided it is tailored as closely as possible to the individual learning style of the doctor and is realistic within existing resources.

Motivation – a drop in motivation through being stressed, bored, bullied or overloaded – or conversely being over-motivated, unable to say no, anxious to please, etc. In these cases some form of mentoring, counselling or other form of support may be appropriate and /or addressing organisational issues like workload, team dysfunction or other environmental difficulties that may be affecting motivation.

Distraction – something happening outside work to distract the doctor; or a distraction within the work environment (noise or disruption; team dysfunction). The doctor may need to be encouraged to seek outside professional help if the problem is outside work.

Health – an acute or chronic health problem which may in turn affect capacity, learning or motivation. Occupational health may have a role here; or the doctor may need to be encouraged to visit his or her GP.

Alienation – a complete loss of any motivation, interest or commitment to medicine or the organisation, leading to passive or active hostility, “sabotage” etc. This cannot generally be rectified and damage can be caused to others (patients and colleagues) and to the organisation if allowed to continue for too long. The doctor should be moved out of the organisation, with whatever support or disciplinary measures may be deemed appropriate.

Investigation

Have you talked to the trainee to gain their perspective?

Have you talked to staff/colleagues confidentially to verify your findings?

Is there any documentary evidence?

Can you talk to other professionals concerned with the trainee’s welfare e.g. GP (with their permission)?

Management

Have you clearly documented any information or evidence you have discovered?

Have you discussed the purpose of this documentation with the trainee?

Does the trainee understand that the appraisal process is confidential but that some documentation of problems is necessary for regulatory purposes and can you agree on this?

Can and should the trainee remain at work?

Is this a case for a trust disciplinary procedure or referral to the GMC?

Management Plan

Have you developed and agreed a suitable learning plan with the trainee?

Can you organise and commit to increased and regular supervision?

When will re-appraisal and reassessment take place?

If problems are not or cannot be resolved should this be referred on to the clinical or college tutor /training programme director?

Further guidance about how and when to act on these concerns is provided below in the Process Flowchart (Appendix 2).

mgt/mr/DID/April2008



Southern Health
and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

23 September 2010

1.0 Introduction

- 1.1 Maintaining High Professional Standards in the Modern HPSS**
A framework for the handling of concerns about doctors and dentists in the HPSS (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.
- 1.2** This document seeks to underpin the principle within the MHPS Framework that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patient's harmed.
- 1.3** The MHPS framework is in six sections and covers:
- I. Action when a concern first arises
 - II. Restriction of practice and exclusion from work
 - III. Conduct hearings and disciplinary procedures
 - IV. Procedures for dealing with issues of clinical performance
 - V. Handling concerns about a practitioner's health
 - VI. Formal procedures – general principles
- 1.4** MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.
- 1.5** This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.
- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

1.6 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.7 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.8 This guidance should be read in conjunction with the following documents:

Annex A

“Maintaining High Professional Standards in the Modern NHS”
DHSSPS, 2005

Annex B

“How to conduct a local performance investigation” NCAS, 2010

Annex C

SHSCT Disciplinary Procedure

Annex D

SHSCT Clinical Manager’s MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1 NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also indicates that anonymous complaints and concerns based on ‘soft’ information should be put through the same screening process as other concerns.
- 2.2 Concerns¹ should be raised with the practitioner’s Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.
- 2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

¹ Examples of Concerns may include: - when any aspect of a practitioner’s performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

- 2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

- 2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expeditiously as possible and the Oversight Group will monitor progress.
- 2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following

informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

- 2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.
- 2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
- Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1

An informal process. This can lead to resolution or move to:

Appendix 2

A formal process. This can also lead to resolution or to:

Appendix 3

A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4

An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5

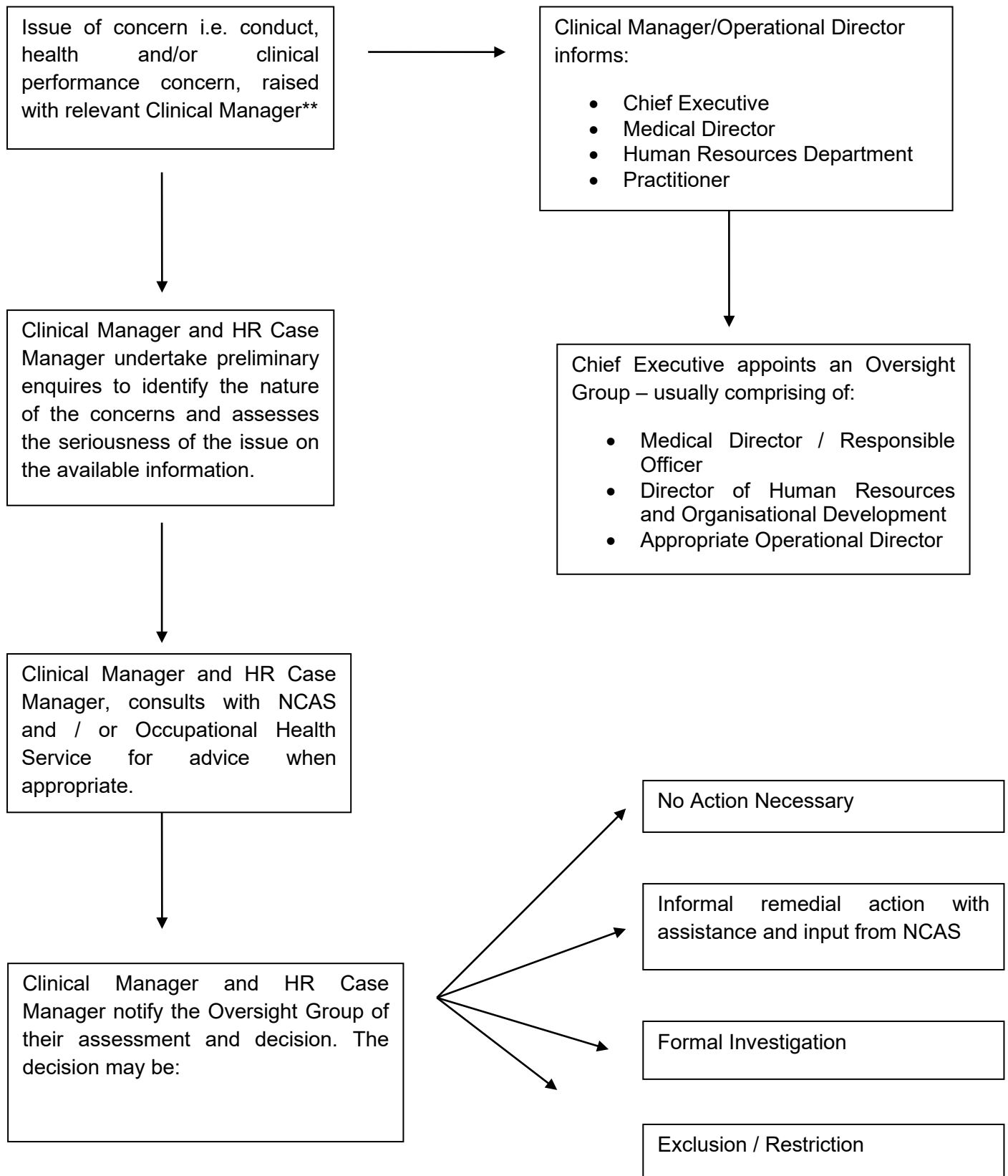
Exclusion can be used at any stage of the process.

Appendix 6

Role definitions

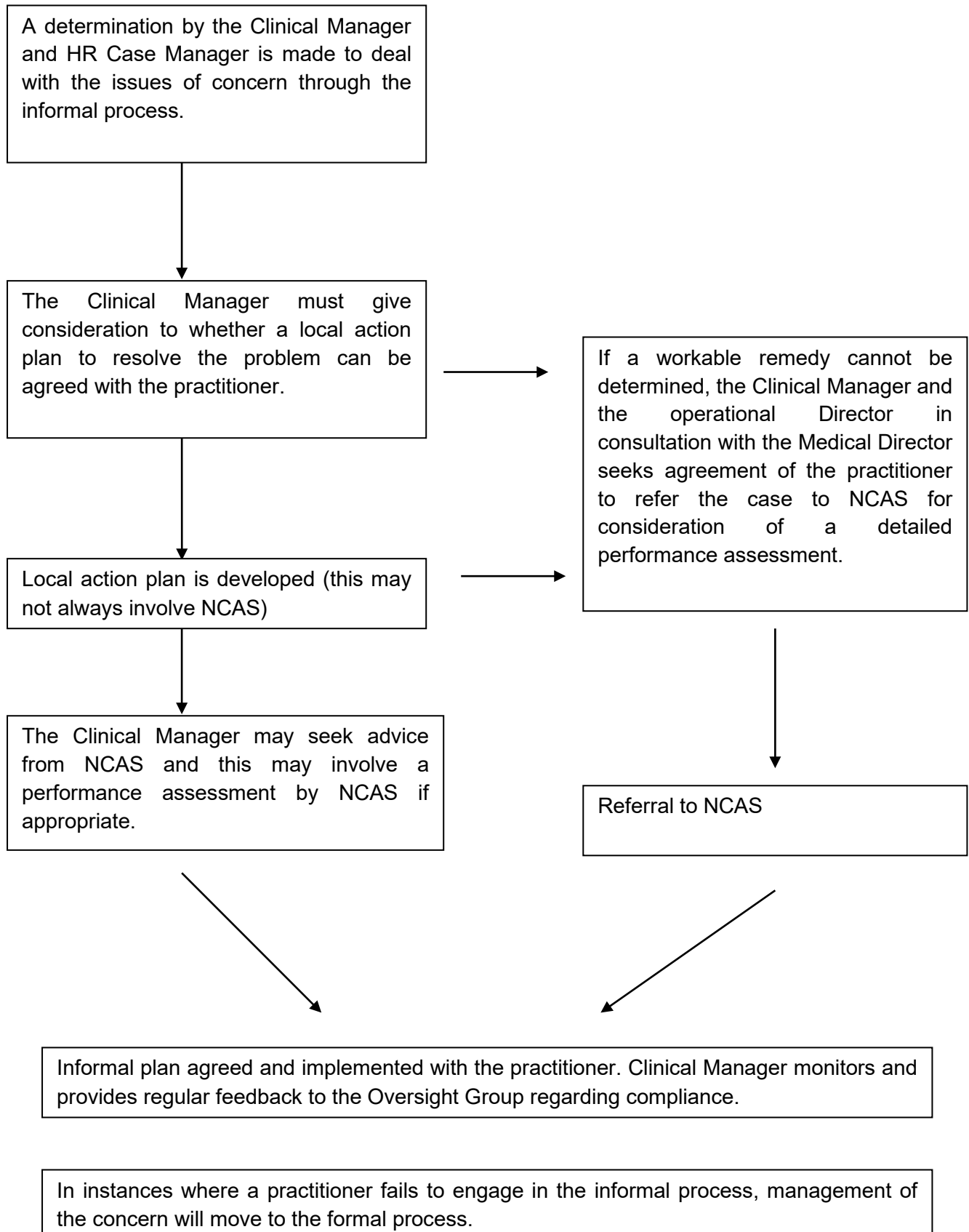
- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.
- 3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).
- 3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.
- 3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, 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 not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

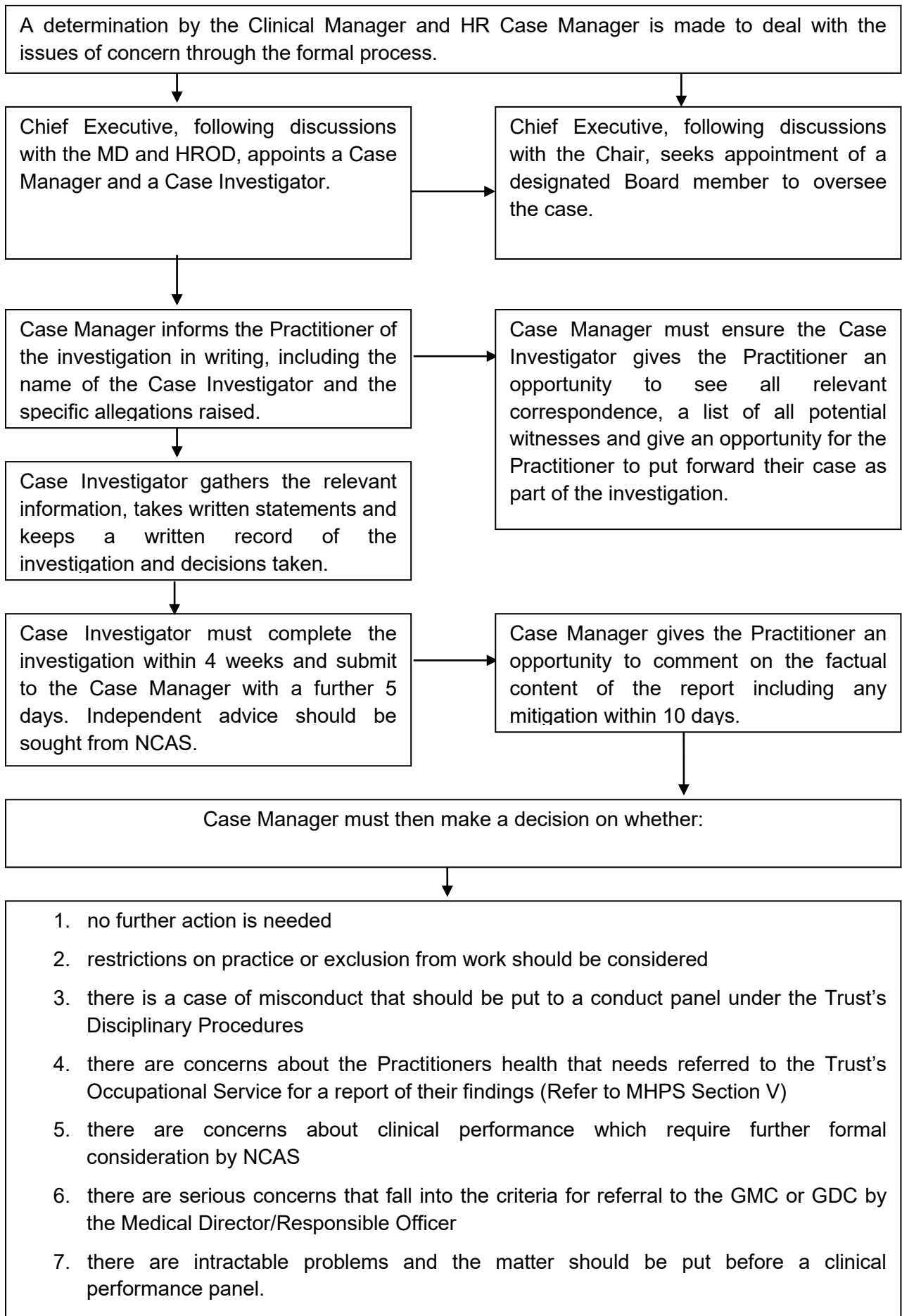
Step 1 Screening Process

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

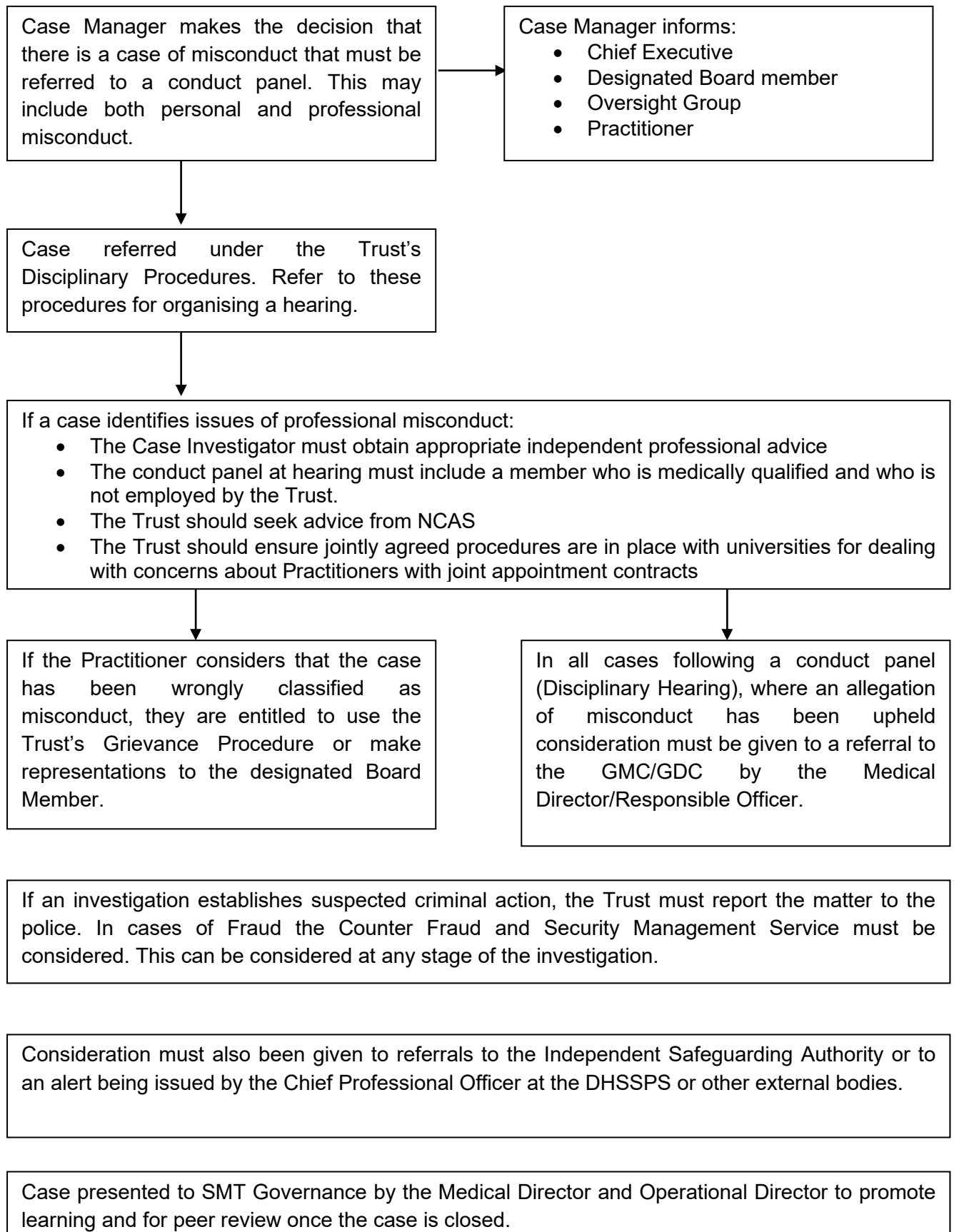
Appendix 1

Step 2 Informal Process

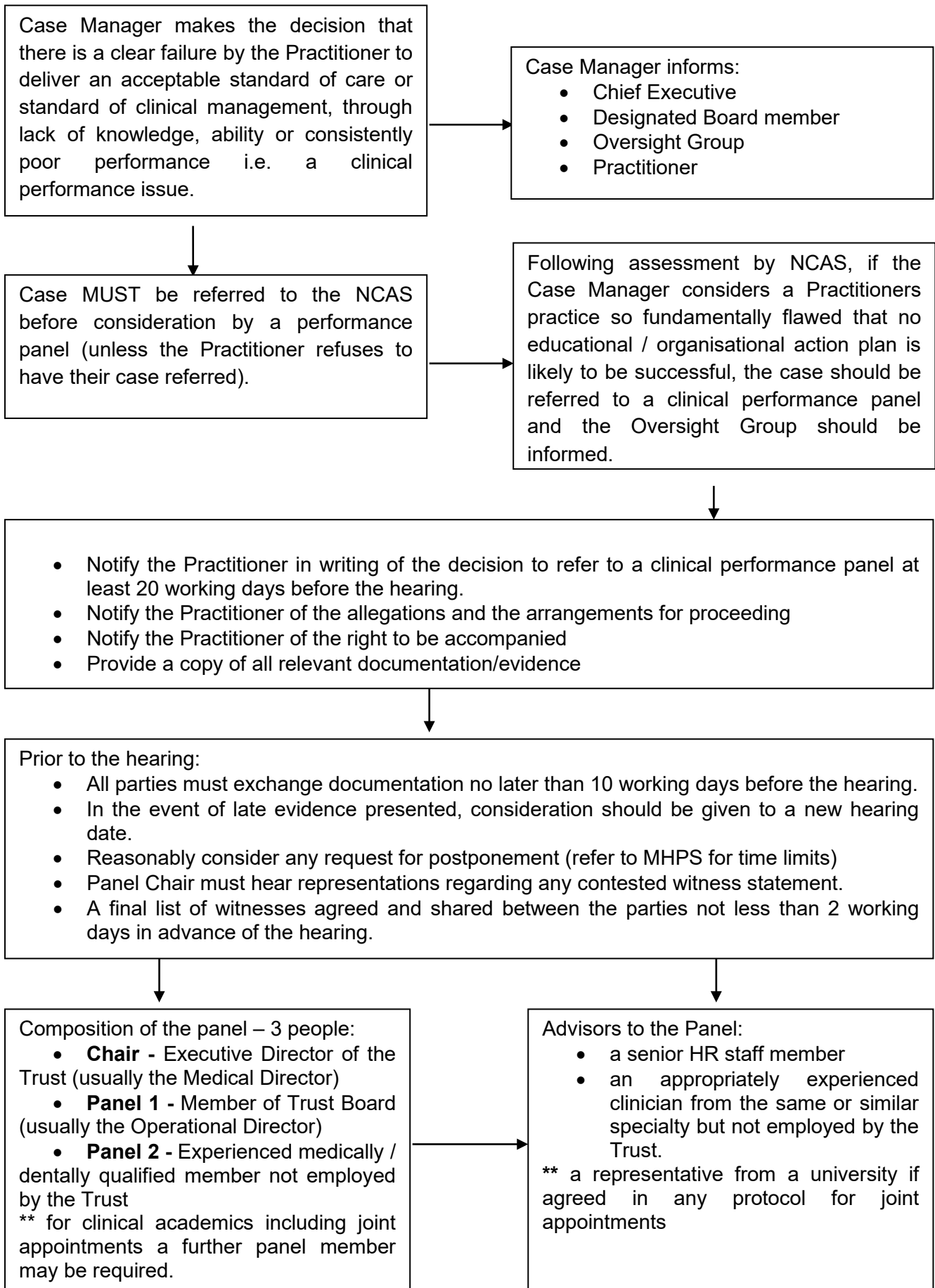
Appendix 2

Formal Process

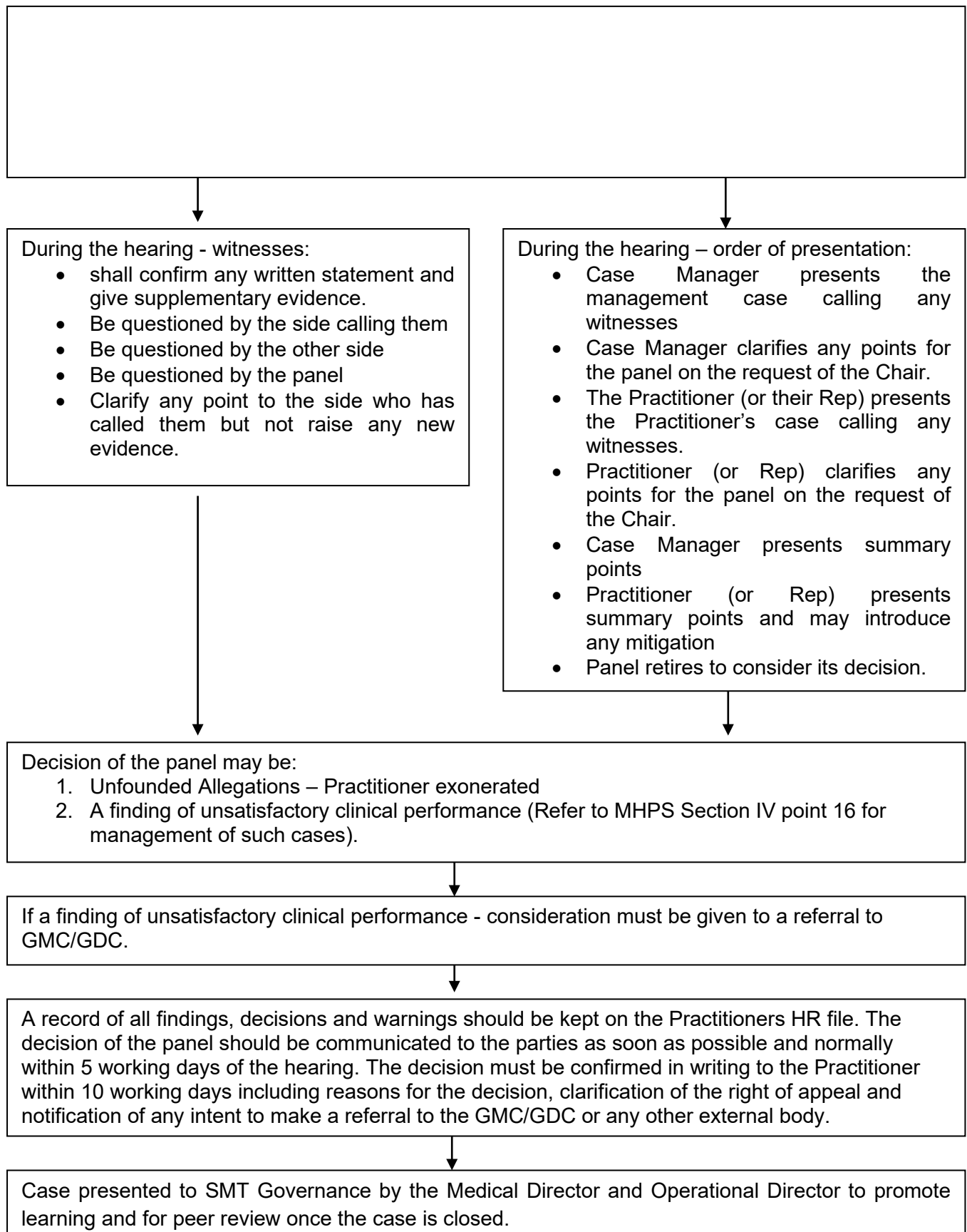
Appendix 3

Conduct Hearings / Disciplinary Procedures

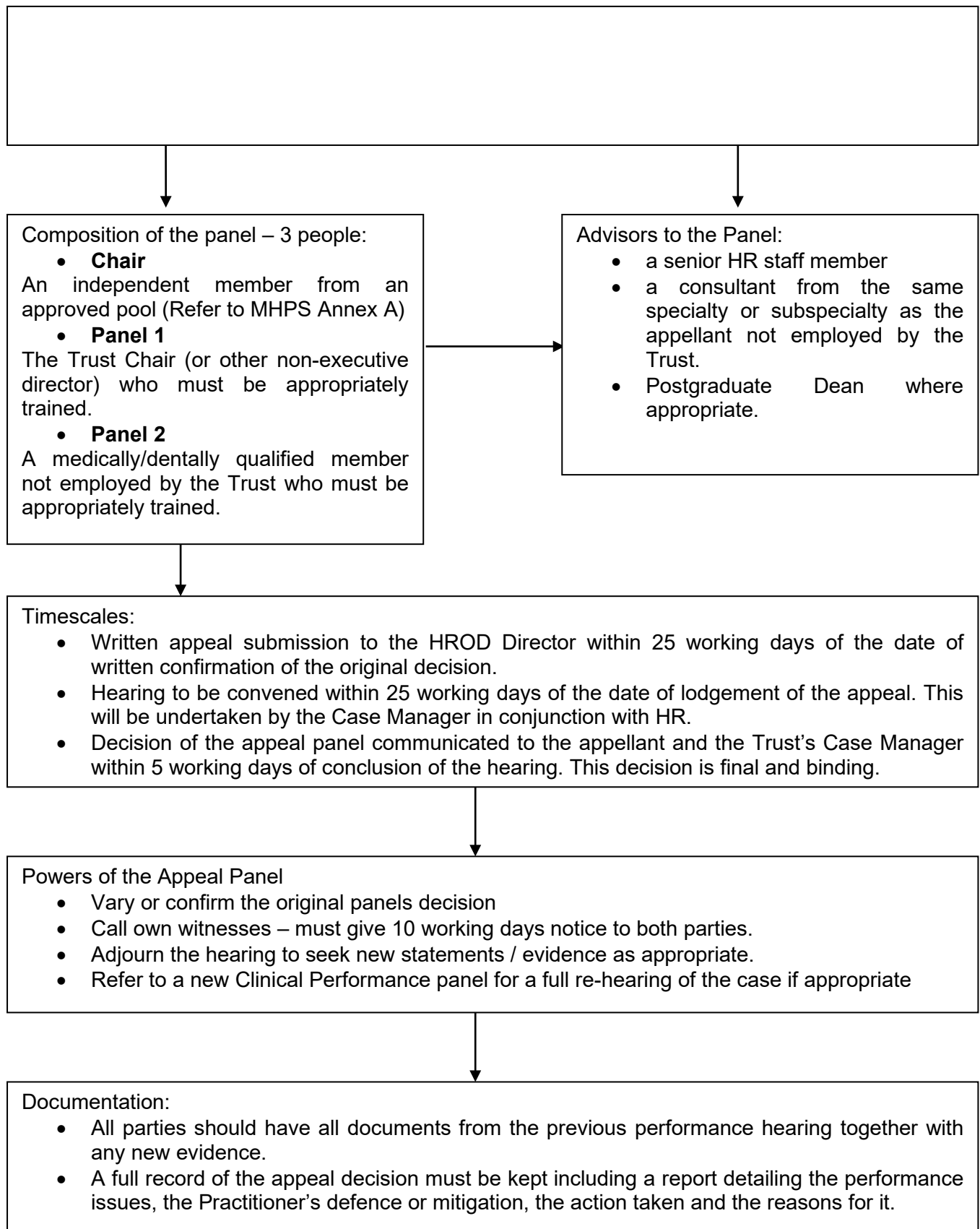
Appendix 3a

Clinical Performance Hearings

Appendix 3a

Clinical Performance Hearings

Appendix 4

Appeal Procedures in Clinical Performance Cases

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

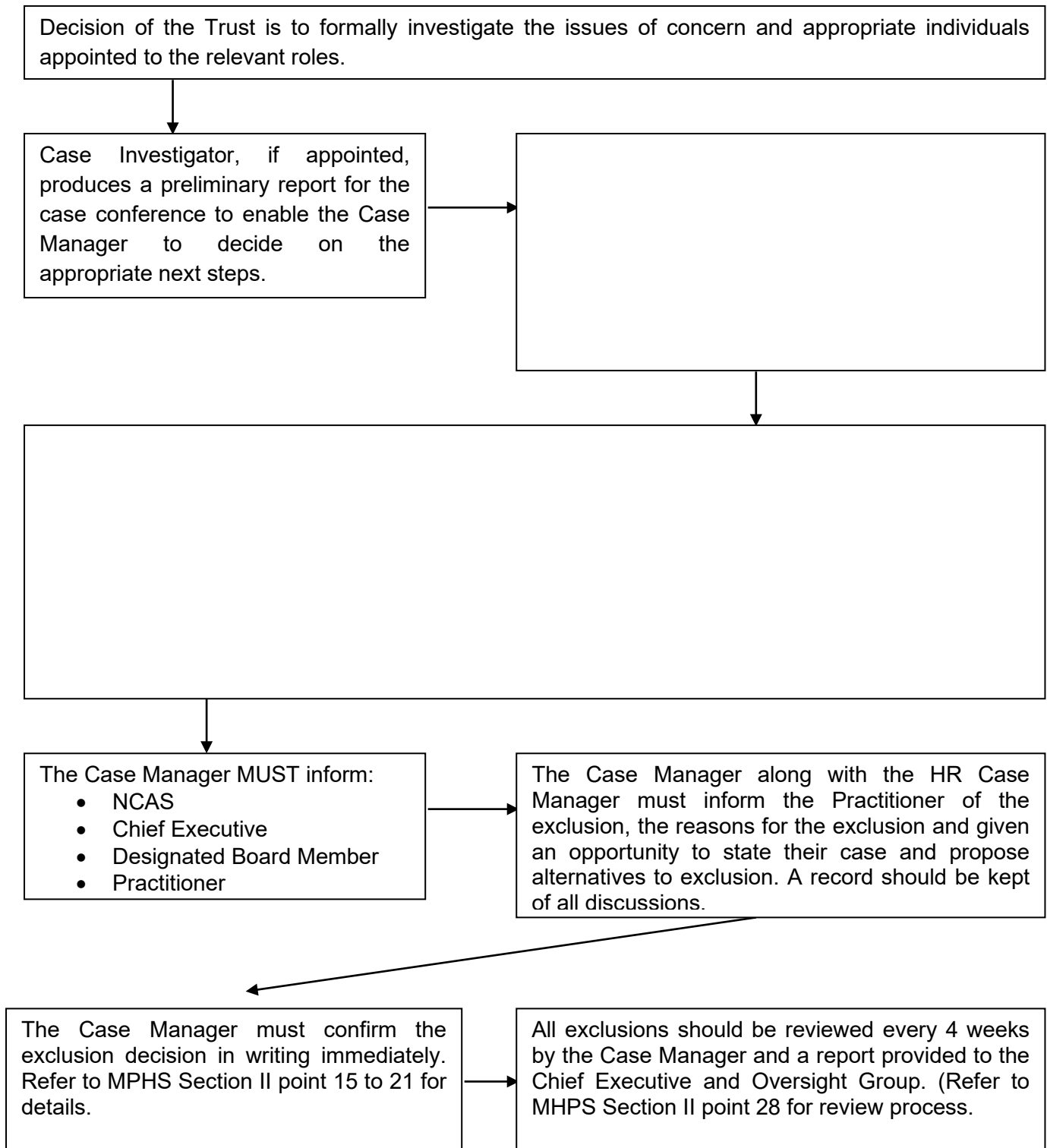
The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work**Formal Exclusion**

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

2018



Southern Health
and Social Care Trust

Quality Care - for you, with you

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

October 2017



INTRODUCTION

- 1.1 Maintaining High Professional Standards in the Modern HPSS:** A *framework for the handling of concerns about doctors and dentists in the HPSS* (hereafter referred to as (MHPS)) was issued by the then Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides the legally binding framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction of practice or suspension (known in MHPS as exclusion).
- 1.2** This guidance document seeks to underpin the principle within MHPS that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patients harmed.
- 1.3** MHPS is in six sections and covers:
- I. Action when a concern first arises
 - II. Restriction of practice and exclusion from work
 - III. Conduct hearings and disciplinary procedures
 - IV. Procedures for dealing with issues of clinical performance
 - V. Handling concerns about a practitioner's health
 - VI. Formal procedures – general principles
- 1.4** MHPS states that each Trust must have in place procedures for handling concerns about an individual's performance which reflect the framework. This guidance, in accordance with MHPS, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response must be the same, i.e. to:
- a) *Ascertain quickly what has happened and why.*
 - b) *Determine whether there is a continuing risk.*
 - c) *Decide whether immediate action is needed to remove the source of the risk.*
 - d) *Establish actions to address any underlying problem.* MHPS Intro Para10
- 1.5** This guidance also seeks to take account of the role of Responsible Officer and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems. [Refer: Responsible Officer NI legislation](#)

- 1.6** This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.
- 1.7** This guidance should be read in conjunction with the following documents:
- Annex A
“Maintaining High Professional Standards in the Modern NHS” DHSSPS, 2005
 - Annex B
“How to conduct a local performance investigation” NCAS, 2010
 - Annex C
SHSCT Disciplinary Procedure
 - Annex D
SHSCT Bullying and harassment Procedure

2.0 WHAT IS A CONCERN?

- 2.1** The management of performance is a continuous process which is intended to identify problems early to ensure corrective action can be taken. Everyone has a responsibility to raise concerns to ensure patient safety and wellbeing. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which do not necessarily require formal investigation or resort to disciplinary procedures.
- 2.2** Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:

MHPS Section1 para 2

- *Concerns expressed by other HPSS (HSC) 1staff*
- *Review of performance against job plans and annual appraisal*
- *Monitoring of data on clinical performance and quality of care*
- *Clinical governance, clinical audit and other quality improvement activities,*
- *Complaints about care by patients or relatives of patients*
- *Information from the regulatory bodies*
- *Litigation following allegations of negligence*
- *Information from the police or coroner*
- *Court judgements or*
- *Following the report of one or more critical clinical incidents or near misses*

- Failure to report concerns

2.3 Concerns can also come to light where a member of staff raises a complaint in relation to poor behaviour they find threatening, humiliating, unwanted, unwelcome or unpleasant. In line with the Trust's Conflict, Bullying and Harassment in the workplace policy, harassment can represent a single, serious incident or persistent abuse.

2.4 If it becomes evident that an individual or individuals were aware of a concern(s) but did not escalate or report it appropriately – this in itself can also represent a concern, which may necessitate intervention, particularly where there are patient safety implications.

2.5 WHO TO TELL?

2.5.1 A concern of any kind should be raised with the practitioner's immediate Clinical Manager. This will normally be the doctor's supervising consultant e.g:

Concerns relates to	Clinical Manager
Junior Doctor/SAS Doctor:	Supervising Consultant
Consultant	Clinical Director
Clinical Director	Associate Medical Director
Associate Medical Director	Medical Director

2.6 NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) (the NCAS guide) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The NCAS Guide also indicates that anonymous complaints and concerns based on ‘soft’ information should be put through the same screening process as other concerns.

3.0 SCREENING PROCESS / *Preliminary Enquiries* MHPS Section1 para 15

3.1 AS CLINICAL MANAGER - WHAT ACTION DO I TAKE?

3.1.1 If you receive a complaint or concerns are raised with you, the first step is to seek advice from the Medical HR Manager and have a “Screening of the Concern” to establish the immediate facts surrounding the complaint. This can include any documentary records such as timesheets/ written statements from the member of staff who raised concern and any other witnesses. At this stage, you are only seeking information that is **readily available**.

3.1.2 **Important:** There is **no** need at this stage to be inviting people to formalised investigative meetings as this would be part of any subsequent investigation process if needed. There may be certain circumstances however where an initial meeting will be necessary to establish facts and

provide an opportunity for the practitioner to hear the concerns and respond which can help determine what, if any action needs to be taken. In any event you will need to inform the practitioner who is the subject of the concerns, advising that you are making them aware of the complaint as part of this process. Do this sensitively and reconfirm that you are establishing the facts and no formal process has been entered into at this time. Assure the individual you will keep them informed and the matter will be progressed at pace.

3.1.3 The purpose of this stage is to gather enough information to enable the Clinical Manager, supported by a senior HR Manager to assess the seriousness of the concern/complaint raised and help inform and rationalise whether this needs to be resolved through a more formal route or informally.

3.1.4 It is important that the process is transparent. Early communication and discussion with the practitioner concerned, aimed at improving their performance or conduct may be sufficient to resolve the issue and identify early interventions to facilitate a resolution. The practitioner's early response can be helpful in deciding whether to carry out an investigation.

3.1.5 Contact with the practitioner who could potentially be subject to a formal investigation may not be appropriate if a counter fraud agency or the police advise early meetings or early disclosure could compromise subsequent investigations. The Director of HR will ensure there is close liaison with the CFPS and/or PSNI in such cases

3.1.6 In situations where a practitioner's ill health may be a significant contributory factor to their conduct or performance then appropriate advice should be sought from the Occupational Health Department.

3.2 DIFFERENCE BETWEEN SCREENING OF CONCERNS AND FORMAL INVESTIGATION

Screening / Establishing Facts (Informal)	Investigation (formal)
Clinical Manager gathering facts /information that has given rise to concern – readily available	Case Investigator – trained in MHPS and equality has been appointed by the Case Manager - this would not ordinarily be the supervising consultant.
Information readily available is gathered quickly, surrounding the concern/complaint	Investigation is directed by Terms of Reference established and agreed by Medical Director/Case Manager
The practitioner has been made aware	Individual would have been notified formally

informally that there is a concern	by Med Director /case manager that a formal investigation under MHPS is being commenced
Issue is managed locally with general advice from NCAS or Occupational Health if appropriate	Case has been formally logged with NCAS
No notice is required i.e. no invite to formal meeting	Right to notice to prepare following formal invite to a meeting in writing
Normally the initial meeting is between the manager and the individual concerned.	Right of representation applies
Progress is being managed locally with HR support	Progress is being monitored by a nominated NED – Case manager/ Medical Director and HR/CEO
No formal process to follow	Any action must be in line with MHPS /Trust disciplinary procedure for medical staff

3.3 SUPPORT FOR DOCTORS DURING SCREENING

Clinical Managers must consider the emotional wellbeing of individuals throughout this process and must not underestimate the impact this may have on a practitioner, so should be encouraged to seek assistance through the Occupational Health department and/or Care Call counselling services. The practitioner should be reminded that support is also available to them through their trade union representative and/or medical defence organisation.

3.4 WHAT HAPPENS AT THE END OF SCREENING PROCESS

The Clinical Manager and the nominated senior Human Resources Manager will be responsible for screening the concerns raised and assessing what action should be taken in response. In line with MHPS Section 1 para 15, this decision will be taken in consultation with the Medical Director, Director of HR and operational Director. Possible action could include:

3.4.1 Action in the event that reported concerns have no substantial basis or are completely refuted by other evidence.

No further action is required. The reasons for this decision should be documented and held by the responsible clinical manager.

3.4.2 Action in the event that there are minor shortcomings

Minor shortcomings can initially be dealt with informally. The practitioner's Clinical Manager will be responsible for discussing the shortcomings with a view to identifying the causes and offering help to the practitioner to rectify them. Such counselling will not in itself represent part of the disciplinary procedures, although the fact and date that counselling was given, should be

recorded on a file note and retained on the practitioner's individual file.

3.4.3 A local action plan can be developed to address the issues with advice from NCAS if appropriate. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

3.4.4 In some cases, the Clinical Manager may feel it is appropriate to give an informal warning without a disciplinary investigation or hearing for the purposes of improving behaviour and in order to assist the practitioner to meet the standards required. The informal warning should be confirmed in writing to the practitioner. Advice must be sought from the Medical HR Manager. This is not a formal disciplinary sanction.

3.4.4 Action in the event that potentially serious shortcomings are identified or previous informal action has not resulted in the required change.

When potentially significant issues relating to performance are identified which may affect patient safety, the matter must be immediately escalated to the Associate Medical Director/Medical Director and Operational Director to consider whether it is necessary to consider 'Immediate Exclusion' from work (Refer to MHPS Section 1 para 18-27).

Depending on the facts of a particular case, it may be necessary to place temporary restrictions on a practitioner's practice. Any voluntary agreement to restrictions should be recorded in writing including any undertaking to apply the same restrictions in any practice elsewhere (outside the Trust employment).

The Medical HR Manager must also be informed of any action taken to ensure the Chief Executive is notified and the correct procedures are followed including the necessity for NCAS to be informed prior to any immediate exclusion. (Reference Section 1 Para19 MHPS)

A Formal Investigation will usually be appropriate where the screening process identified information to suggest that the practitioner may pose a threat to patient safety, expose services to financial or other substantial risk, undermine the reputation or efficiency of services in some significant way or work outside acceptable practice guidelines and standards. (NCAS Good Practice Guide Section 1: pg. 7) In these situations, a thorough and robust investigation and report will help to clarify any action needed. Before the investigation proceeds, consideration will also be given to the appropriate protection and support that needs to be afforded to patients, those raising concerns, and the practitioner. (Refer to NCAS Good Practice Guide Section 2)

The Medical Director will then appoint a Case Manager, Case Investigator and Designated Board Member (on behalf of the Chief Executive). The Medical Director (which may be delegated to the Case Manager) should then draft the Terms of Reference for the formal investigation and the formal approach as set out in MHPS Section 1 para 28-41 will be followed.

During all stages of the process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, 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 not acting in a legal capacity. Refer MHPS Section 1 Para 30.

4.0 SUMMARY

- 4.1** The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1

Screening Process This can lead to resolution or move to:

Appendix 2

A formal investigation process. This can also lead to resolution or to:

Appendix 3

A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4

An appeal panel can be invoked by the practitioner following a panel determination.

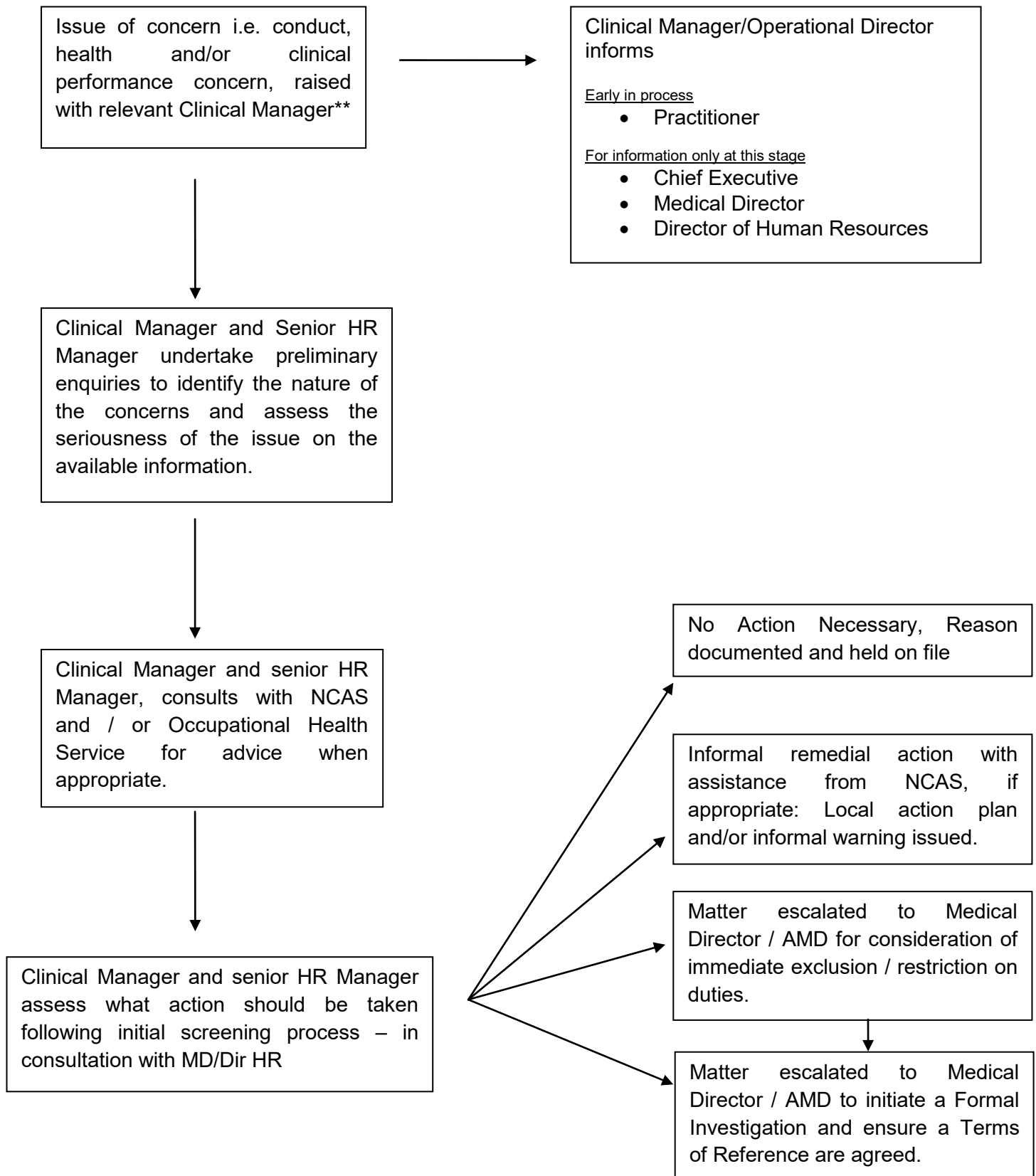
Appendix 5

Formal exclusion can be used in the context of a formal investigation

Appendix 6

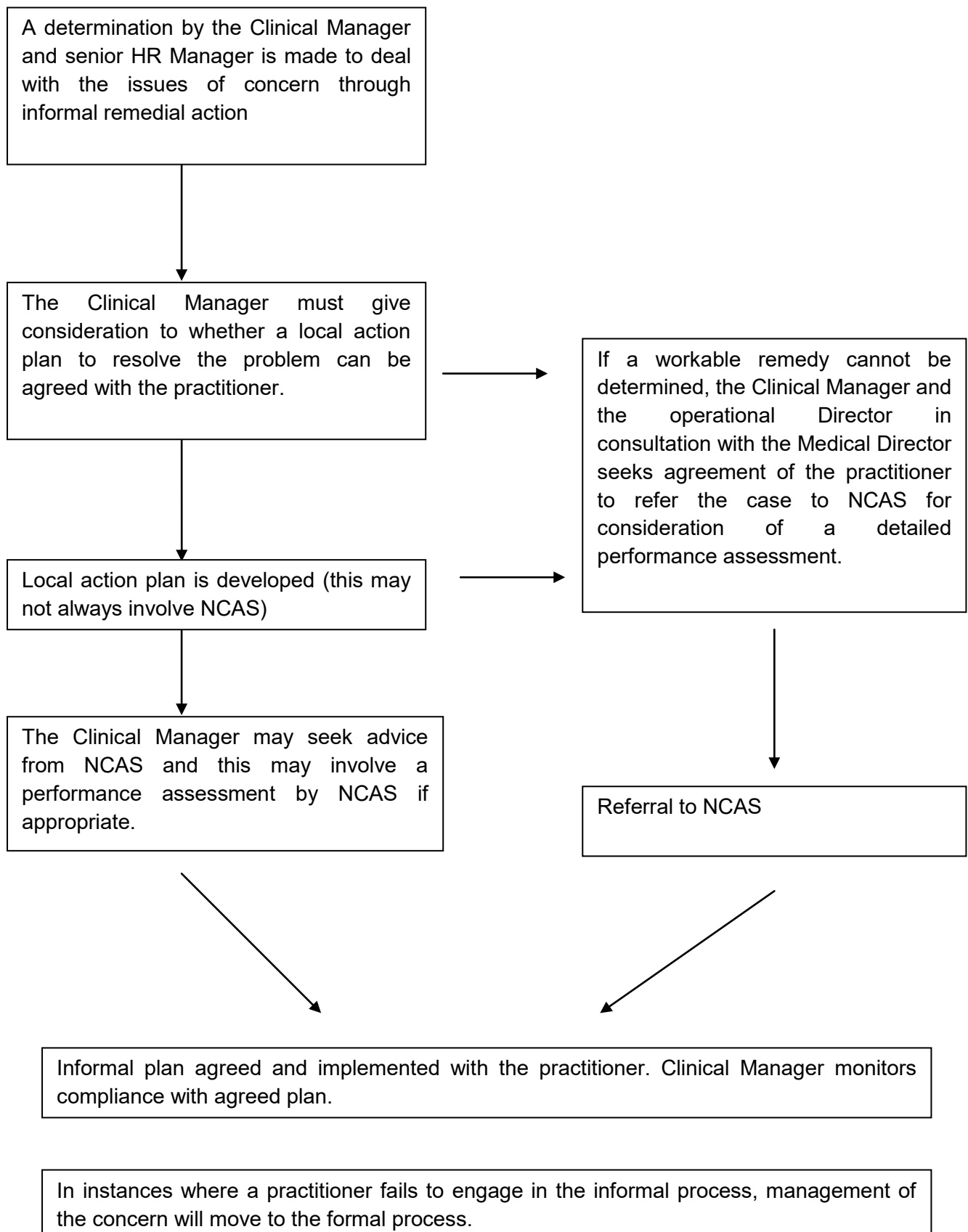
Role definitions

Appendix 1

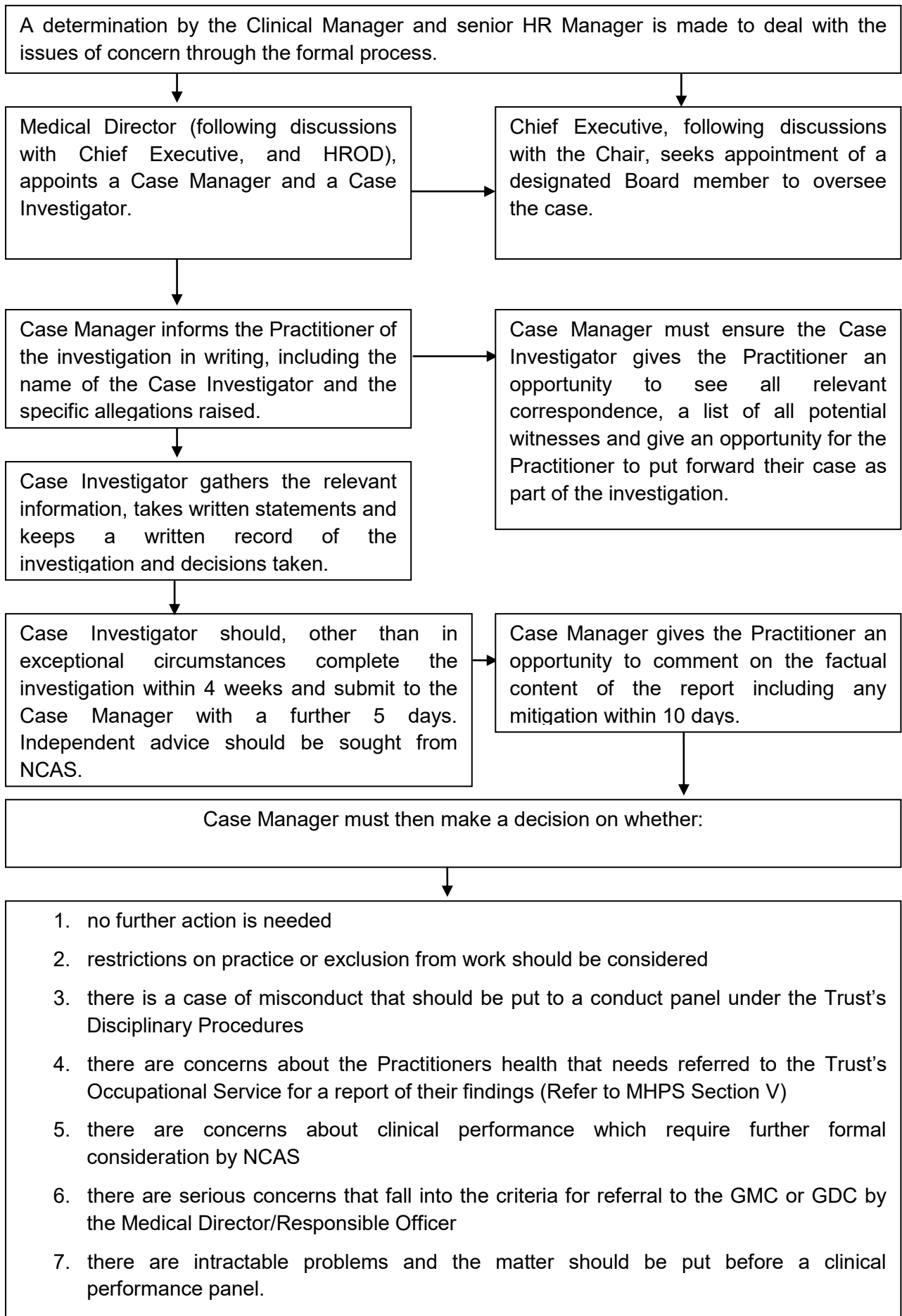
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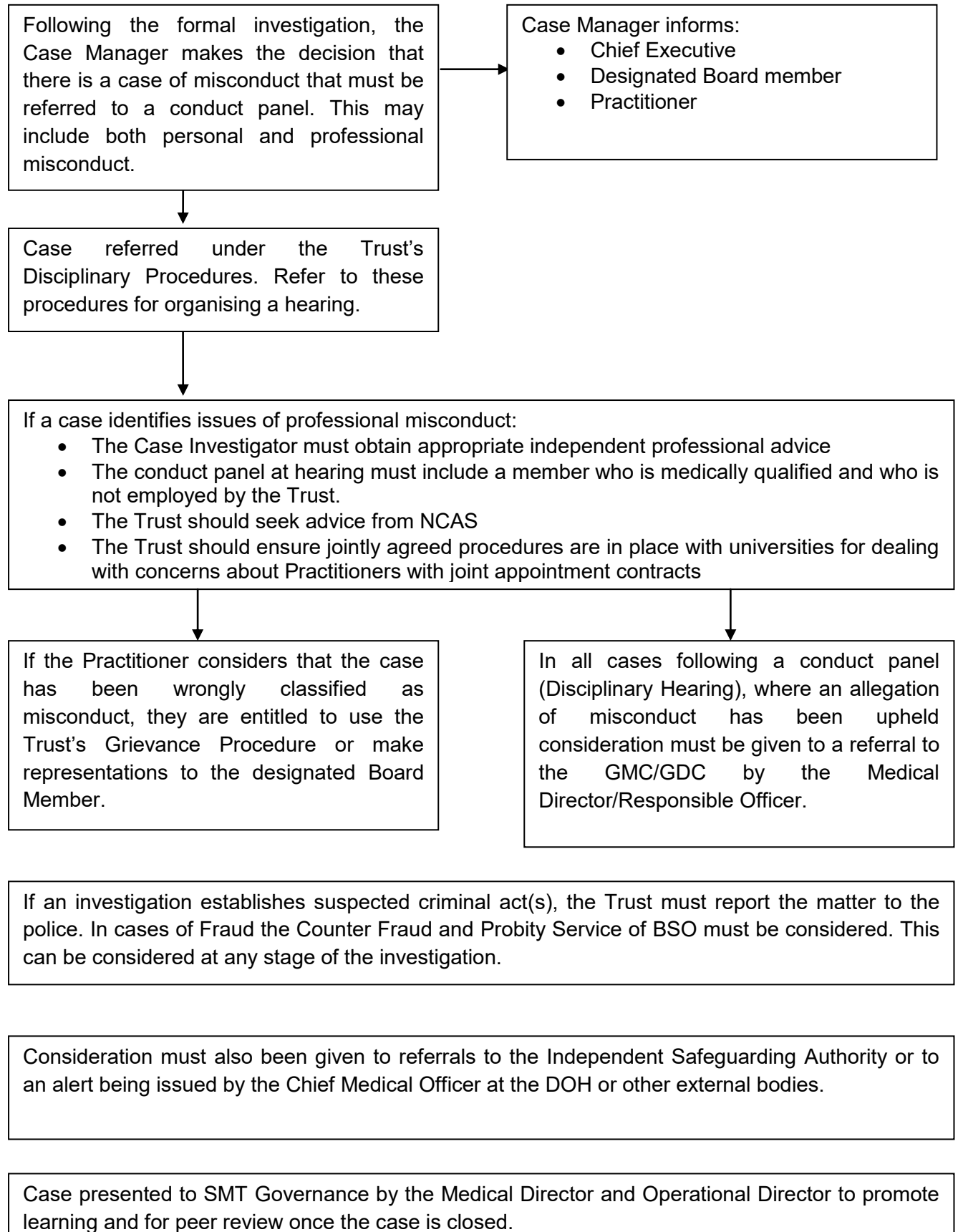
Informal Remedial Action

Appendix 2

Formal Investigation Process

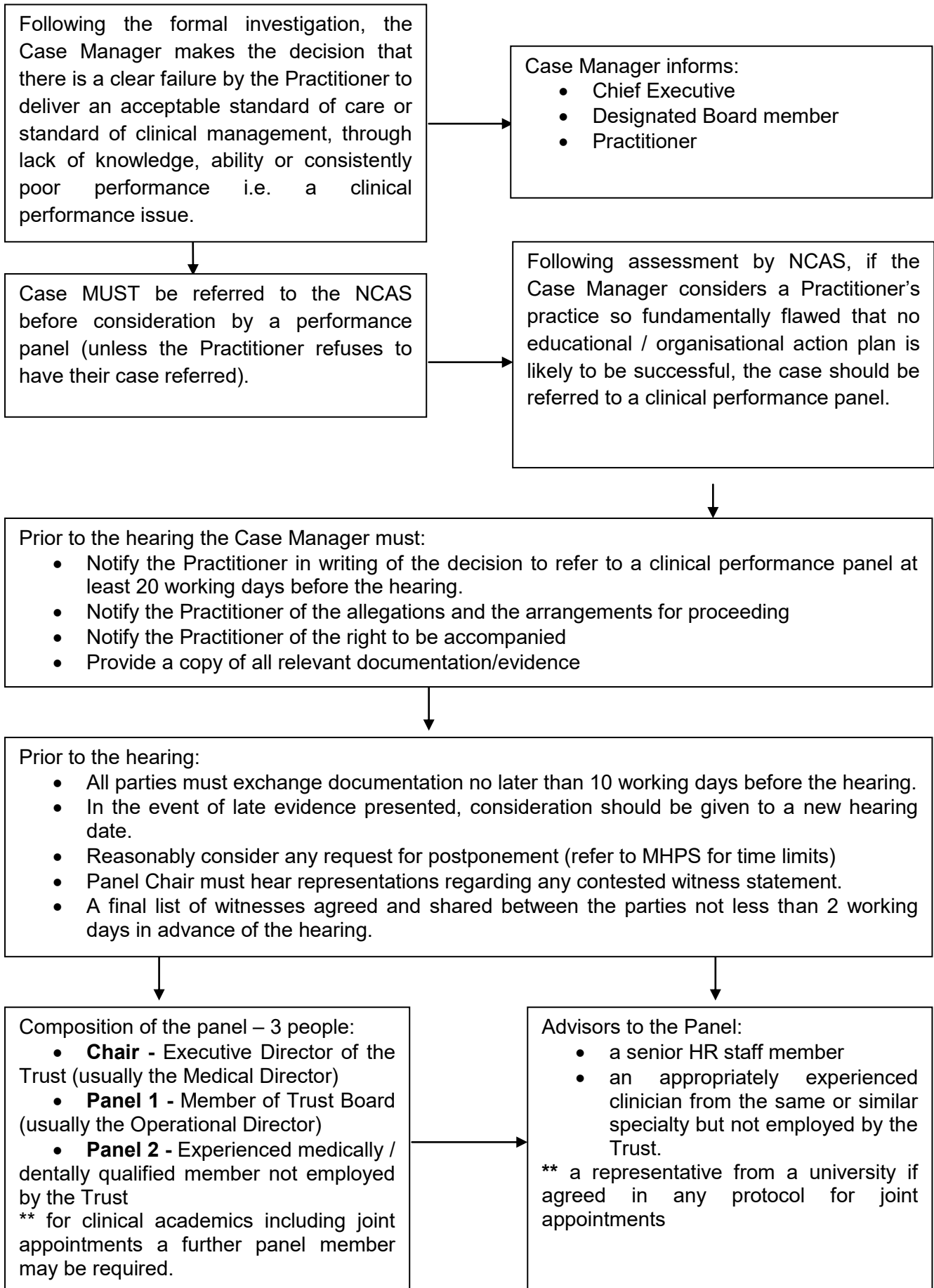
Appendix 3

Outcome of Formal Investigation: Conduct Hearings / Disciplinary Procedures

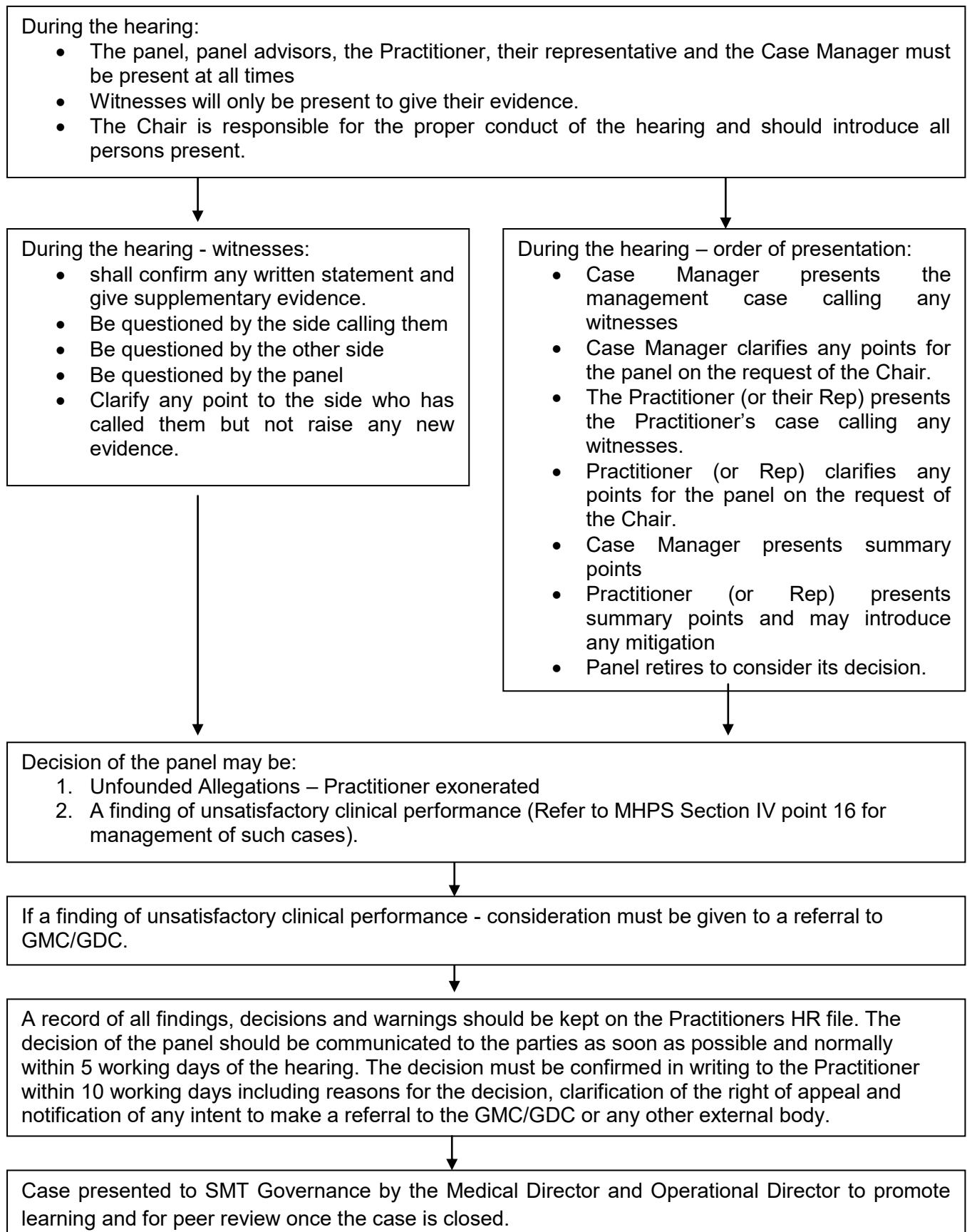


Appendix 3a

Outcome of Formal Investigation: Clinical Performance Hearings



Appendix 3a

Clinical Performance Hearings

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerns and/or their colleagues. (MHPS Section II para 6)
- Exclusions may be up to but no more than 4 weeks at a time.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions.

Immediate Exclusion

A proposal to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director or Associate Medical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis. MHPS Section 1: para 18-27.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Medical Director and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

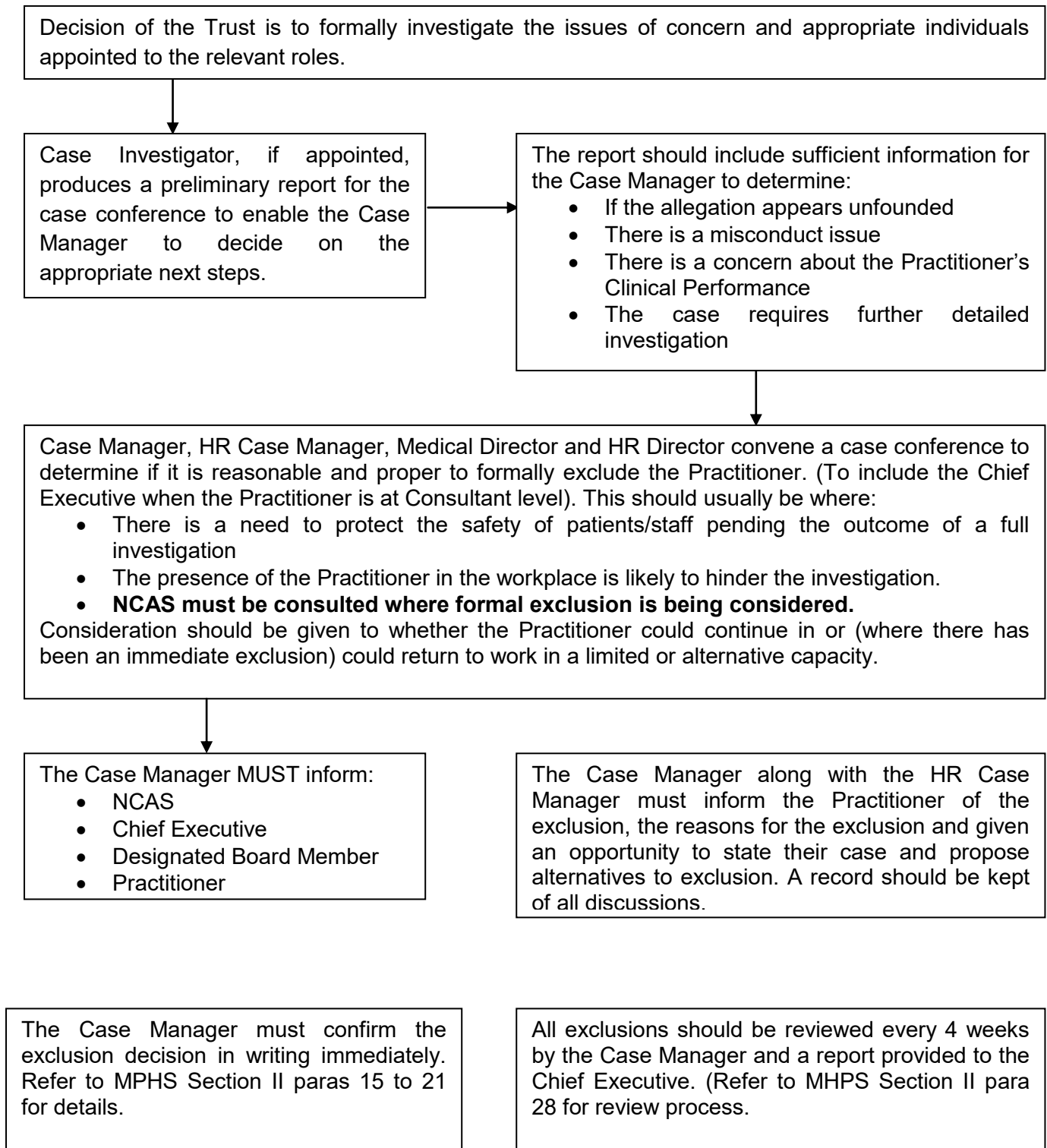
The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work (Section II MHPS)**Formal Exclusion**

Appendix 6

Role definitions and responsibilities**Screening Process / Informal Process****Clinical Manager**

This is the person to whom concerns are reported. This will normally be the supervising Consultant, Clinical Director or Associate Medical Director (although usually the Supervising consultant/Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial screening assessment along with a HR Case Manager.

Formal Process**Chief Executive**

The Chief Executive in conjunction with the Medical Director appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of the formal investigation and request that a Non-Executive Director is appointed as “designated Board Member”.

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work nor should he/she make recommendations.

Note: Should the concerns involve a Clinical Director, the Case Manager should normally be the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager should normally be the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust.

Any conflict of interest should be declared by all parties before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must oversee the case to ensure momentum is maintained and consider any representation from the practitioner about his or her exclusion or any representations about the investigations.

Toal, Vivienne

From: Vivienne Toal <[Personal Information redacted by the USI]>
Sent: 09 August 2010 16:23
To: Siobhan Hynds
Subject: FW: Managing Poor Clinical Performance - ammended paper
Attachments: RE_ Process and Guidelines for Managing Underperformance (Medical Sta....eml (316 KB); Managing Poor Performance - ncas draft.doc

From: McCullough, Elizabeth ([Personal Information redacted by the USI])
 Sent: 06 August 2010 17:44
 To: Vivienne Toal
 Subject: FW: Managing Poor Clinical Performance - ammended paper
 Importance: High

Vivienne

I'm not sure what I've attached is what Kieran is referring to in his email below. Can you take a look and see – if not, let me know.

Thanks
 Elizabeth

From: Donaghy, Kieran
 Sent: 04 August 2010 18:03
 To: Toal, Vivienne
 Cc: Hynds, Siobhan; McCullough, Elizabeth
 Subject: FW: Managing Poor Clinical Performance - ammended paper
 Importance: High

Vivienne,

Both Debbie Burns and [redacted] are both doing developing seperate papers to reflect dealing with under performing doctors (who needs HR). Debbie's is an overview that goes into flow charts and provides a useful reference point Ann Brennans paper goes into a great deal of detail and is raises a few interesting details that certainly I wasn't aware of. At a meeting with Mairead & Paddy this morning we agreed Debbies paper with a number of amendments. These are now enclosed. I'll ask Elizabeth to forward details of Anns paper.

Could you have a look and let me have your comments asap.

Kieram

From: Burns, Deborah
 Sent: 04 August 2010 17:28
 To: McAlinden, Mairead; Donaghy, Kieran; Loughran, Patrick
 Cc: Wright, Elaine
 Subject: Managing Poor Clinical Performance - ammended paper
 Importance: High

Hi all

Following our meeting this am please find attached draft 2 of the paper with ammendments inserted - comments welcome. Jennifer is pulling us together again as requested by the CE Thanks D Debbie Burns Assistant Director Performance Improvement Southern Trust

Email: Personal Information redacted by the USI

Tel: Personal Information redacted by the USI

Procedure for Handling Concerns **about Doctors' and Dentists'** Performance

Southern Health and Social Care Trust

Procedure for Handling Concerns about **Doctors' & Dentists' Performance** Southern Health and Social Care Trust

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1.0 Background

This procedure is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been developed to reflect the framework set out in HSC2003/012, "Maintaining High Professional Standards in the Modern NHS".

This policy applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust.

This policy and procedure applies to the management of performance and capability issues.

This policy is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been devised to reflect the framework set out in HSC2003/012, "Maintaining High Professional Standards in the Modern NHS".

Its provisions cover action to be taken when a concern about a doctor or dentist first arises and action to consider whether there need to be restrictions placed on a doctor's or dentist's practice or exclusion from work is considered necessary.

The new approach set out in the 'Maintaining High Professional Standards' framework, and which is reflected in this Procedure, builds on four key elements:

- Appraisal and revalidation - processes which encourage practitioners to maintain the skills and knowledge needed for their work through continuing professional development;
- The advisory and assessment services of the National Clinical Assessment Service (NCAS) - aimed at enabling Trusts to handle cases quickly and fairly, and reducing the need to use disciplinary procedures to resolve problems;
- Tackling the blame culture - recognising that most failures in standards of care are caused by systems' weaknesses, and not individuals per se;
- Abandoning the 'suspension culture' - by introducing the new arrangements for handling 'exclusion from work'.

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2.0 Purpose

The purpose of this procedure is to:

- Introduce a new approach which recognises the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action
- Establish a clear and co-ordinated process for handling concerns relating to the safety of patients posed by the conduct and/or performance of doctors and dentists, which come to the attention of the Trust. Whatever the source of this information, the response will be the same, i.e. to:
 - Ascertain quickly what has happened and why.
 - Determine whether there is a continuing risk.
 - Decide whether immediate action is needed to remove the source of the risk.
 - Establish actions to address any underlying problem.

The procedure also sets out clear processes, again in accordance with the national framework, for handling disciplinary procedures relating to doctors and dentists. These include dealing with issues of Misconduct and Capability, and handling concerns relating to a practitioner's health.

3.0 Guiding Principles

In the handling of concerns relating to the conduct and performance of doctors and dentists, the following guiding principles will always apply:

- The Trust recognises that unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore, all allegations, including those made by relatives of patients, or concerns raised by colleagues, will be carefully considered and, if required, properly investigated to verify the facts, such that the allegations may be shown to be true or false.
- The Trust will always endeavour to resolve issues as informally as possible, where such issues are not deemed to be of a serious nature.

- Exclusion from work will be used only in the most exceptional of circumstances, and the exclusion of a practitioner will not be viewed as a solution in itself. Furthermore, periods away from work will be kept to the minimum, through effective performance management arrangements, which will ensure that progress with an investigation is maintained and the need for continued exclusion is frequently reviewed (an exclusion will lapse and the practitioner will be entitled to return to work if the exclusion is not actively reviewed).
- The Trust will consult with the NCAS at an early stage, when action in relation to clinical concerns is being considered, and thereafter on a regular basis whilst a case is progressing. The underlying intention is that the early intervention of the NCAS will help the Trust to maintain momentum in resolving concerns about clinical competence, and thereby reduce the number of doctors and dentists who are excluded from their workplace for long periods of time.
- The Trust will work with the NCAS to ensure that, wherever possible, alternatives to exclusion are considered.
- Concerns relating to the Capability of doctors and dentists in training should be considered as training issues, and the Trust's Associate Medical Director of Medical Education & Training will be involved from the outset.
- The Trust supports an open approach to reporting and tackling concerns about doctors' and dentists' practice, and recognizes the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action.
- The Trust will maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Trust will only confirm that an investigation or disciplinary hearing is underway.

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4.0 Procedures when a Concern Arises

4.1 Identification of potential performance issues

Concerns regarding a doctor or dentist's performance can be flagged by a number of formal or informal sources, such as:

- Colleagues or students
- During job planning, appraisal or revalidation processes

- Monitoring of quality or performance data
- Quality improvement activities, such as clinical audit
- Complaints from patients & relatives
- Information from the General Medical Council (GMC), General Dental Council (GDC) or other regulatory bodies
- Litigation following allegations of negligence
- Information from police or coroner
- Court judgements

4.2 Stage 1 - Action when a Concern Arises

When a concern arises, relating to a particular doctor or dentist, the following procedures will be followed: These procedures will allow for informal resolution of less serious problems

The matter will be brought to the attention of the appropriate Clinical Director (CD), or their elected deputy, at the earliest possible opportunity. Should the matter relate to the conduct or performance of a CD, then the Associate Medical Director (AMD) must be informed. The CD/AMD will then inform the Operational Director and Medical Director of the nature of the concern.

All serious concerns must also be registered with the Director of Human Resources and Organisational Development and Chief Executive.

The duty to protect patients is paramount. When a serious concern is raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. **Section XX** of this document sets out the procedures for this action.

4.44.3 Stage ~~3-2~~ - Assess the type and potential seriousness of the issue & whether full formal investigation is required.

On behalf of the Chief Executive, the Medical Director, or nominated representative, in consultation with the HR Director, or nominated representative, will appoint a senior clinician to act as '**Case Manager**' to assess the type and

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potential seriousness of the issue and provide information on whether a full formal investigation is required.

This senior clinician will be appropriately experienced or trained to enable them to carry out this role when required. The Medical Director, or Associate Medical Director, or appointed representative, will act as Case Manager in cases involving Clinical Directors.

~~On the information available, the Case Manager needs to decide, potentially, how serious the issue is and act accordingly. Examples of serious issues include potential gross misconduct or a serious untoward incident.~~

~~Defining the seriousness of an issue is by no means always an easy decision, and the advice of the Medical Director and the Director of Human Resources (or a nominated member of the senior HR team) should be sought. Advice from the NCAS may be sought in cases of professional misconduct or capability.~~

Where there are concerns about a doctor or dentist in training, the Postgraduate Dean and the Director of Medical Education and Training will be informed as soon as possible.

A decision to investigate commits the organization to significant work and expense, so the organization needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

The Trust supports a 'Screening' process using the NCAS 'How to Conduct a Local Performance Investigation' framework to identify whether a formal investigation is needed.

Anonymous complaints or concerns based on 'soft' information should be put through the same screening process as other concerns.

4.3.1 What should be considered in making a decision to investigate?

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The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

The appointed Case Manager should contact have a preliminary meeting with the doctor/dentist, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses.

The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A

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note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter-fraud agency or the police

advise that early meetings or early disclosure could compromise subsequent investigations.

But generally, the

practitioner's response will be helpful in deciding whether to carry out an investigation.

Formal Investigation will usually be appropriate where case information gathered to date suggests that the doctor may:

- Pose a threat or potential threat to patient safety
- Expose services to financial or other substantial risk;
- Undermine the reputation or efficiency of services in some significant way;
- Work outside acceptable practice guidelines and standards

4.3.2 What Alternatives to Full Investigation are Available?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the following circumstances:

- The practitioner may agree that the concerns are well-founded and agree to cooperate with required further action. However, if the issues raised are serious enough to suggest that if upheld they might warrant consideration of termination of employment or removal from a performers list, then the

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organisation may still need to conduct an investigation. The action to be taken subsequently would then be decided in the normal manner.

Defining the seriousness of an issue is by no means always an easy decision, and the advice of the Medical Director and the Director of Human Resources (or a nominated member of the senior HR team) should be sought. Advice from the NCAS may be sought in cases of professional misconduct or capability.

The Case Manager will explore the potential problem with the NCAS to consider different ways of addressing it themselves. In so doing, the Case Manager may possibly recognise the problem as being more to do with work systems than the practitioner's performance, or see a wider problem needing the involvement of an outside body, other than the NCAS.

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The role of the NCAS, and the responsibility of the Trust and individual practitioners towards the NCAS, are detailed in the Management Instructions and Guidelines, at **Appendix 1**.

The Case Manager will not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analysis of adverse events should be conducted as these frequently show that causes 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. The National Patient Safety Agency (NPSA) facilitates the development of an open and fair culture, which encourages doctors and dentists and other NHS staff to report adverse incidents and other near misses and the Case Manager will consider contacting the NPSA for advice about systems or organisational failures.

Having discussed the case with the NCAS and/or NPSA, the Case Manager must decide whether:

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■ there is no case to answer; or

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■ the issue is one that should be resolved through an informal approach; or

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■ the issue is such that a formal investigation is needed.

The decision will be taken following consultation with the Medical Director and HR Director, or their nominated representatives, and ~~the~~ NCAS.

Where an informal route is chosen the NCAS will remain involved until the problem is resolved.

Having discussed the case with the NCAS and/or NPSA, the Case Manager must decide whether:

- there is no case to answer; or
- the issue is one that should be resolved through an informal approach; or
- the issue is such that a formal investigation is needed.

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Where the issue is clearly one of alleged Misconduct or gross Misconduct, due to factors other than those directly involving the exercise of medical and dental duties (e.g. bullying; assault; theft; fraud; failure to fulfill contractual obligations; refusal to comply with the reasonable requirements of the Trust; non-attendance at work; the commission of criminal offences outside the place of work which may, in particular circumstances, amount to Misconduct or gross Misconduct), such issues will be handled under the **Trust Disciplinary Policy**, within the Staff Policy Framework, which applies to all staff.

The procedures associated with the Trust Disciplinary Policy require that a full and thorough investigation is conducted. The Case Manager and HR Manager, or their nominated representatives, are responsible for ensuring these procedures are correctly followed, and the practitioner is kept properly informed about the details of the allegations and the process. The practitioner will also be advised whether the alleged offence amounts to gross Misconduct, which if proven may lead to summary dismissal;

Where the issue involves the exercise of medical and dental duties, or where the nature of the issue is such that the **Case Manager** determines it may lead to either Misconduct or Capability proceedings, the Medical Director will, after discussion between the Chief Executive and Director of Human resources or their nominated representative, appoint an appropriately experienced or trained person as '**Case Investigator**'. The seniority of the Case Investigator will differ, depending on the grade of practitioner involved in the allegation. Several clinical managers will be appropriately trained, to enable them to carry out this role as required.

The Case Investigator is responsible for leading the investigation into the concerns about the practitioner, establishing the facts, and reporting the findings. The role of the Case Investigator is detailed in the Management Instructions and Guidelines, at Appendix 1.

4.54.4 Stage 4 Investigation:

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When it is decided that a formal approach needs to be following the CX, etc appoint a Case Manager, Case Investigations

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As soon as the decision has been taken to commission an investigation, the Case Manager will inform the practitioner, in writing, of the name of the Case Investigator, and of the specific concerns/allegations that have been raised against them (this information will be as comprehensive as possible, in terms of incidents, dates, persons involved, etc.). The practitioner will also be given the opportunity, as early as is reasonably practicable, to see any correspondence relating to the case, together with a list of the individuals the Case Investigator intends to interview. The practitioner will be able to add to this list if important witnesses are not scheduled to be interviewed.

The practitioner will be afforded the opportunity to put their view of events to the Case Investigator and informed of their right, at any stage of this process (or subsequent disciplinary action) to be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. The companion may be legally qualified, but they will not be acting in a legal capacity.

If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the Case Manager should consider whether an independent practitioner from another NHS body should be invited to assist.

The Case Investigator should complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 days.

The Case Manager will review the report and, through further consultation with an **internal Review Committee**, determine whether, or not, there is a case to answer and what action should be taken.

The Review Committee will consist of the Case Manager; Medical Director; HR Director, and the LNC Chair, or their nominated representatives. The NCAS will also be invited to attend. Where it is determined that there is a case to answer, the Case Manager, in consultation with the Review Committee and NCAS, will consider whether restrictions on practice or exclusion from work should be considered, notwithstanding that this action may already have **been taken (see procedures at Section 2)**.

The Case Investigator has no involvement in actual decisions made for action to be taken in the case and must not be a member of any disciplinary panel.

4.64.5 Stage 5 Outcome of investigation

The Case Manager will review the investigation report and make a decision with regards to the way forward. At this stage, it should be decided if the issue is one of **conduct** or one of **capability**:

- **Conduct** – the behaviour of the doctor or dentist is the source of concern. This can include failure or refusal to comply with trust standards. Where an investigation identifies issues of professional misconduct¹ as opposed to personal, the Case Investigator should additionally seek professional advice from a doctor or dentist employed in the same speciality (who has not been involved with the case)

All forms of misconduct should be dealt with under the trust's Disciplinary Procedure

- **Capability** – the ability of the doctor or dentist to perform particular aspects of their role is in question. This is demonstrated by a clear failure by an individual to deliver an adequate standard of care, or standard of management or clinical practice, through lack of knowledge, ability or consistently poor performance.

Inevitably, some cases will involve both Misconduct and Capability issues. These cases are likely to be complex and difficult to manage. Therefore, where a case covers more than one category of problem, they will usually be combined and considered under a Capability hearing. However, there may be occasions where it is necessary to pursue a Misconduct issue and a Capability issue separately. In these difficult cases, the Case Manager, in consultation with the NCAS and the Trust's own employment law advisers, will recommend the most appropriate course of action.

5.0 Action when an Investigation identifies possible Criminal Acts

Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The Trust investigation (under either its Misconduct or Capability Procedure) will only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The Trust will consult the

- ¹ Professional misconduct is defined as actions or behaviour that do not comply with standards of professional behaviour laid down by professional regulatory bodies or failure to comply with the trust's clinical policies.

police to establish whether an investigation into any other matters would impede their investigation.

5.1 Cases where Criminal Charges are brought, not connected with an Investigation

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

5.2 Dropping of Charges or no Court Conviction

When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but it is considered there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to eliminate this risk. Similarly, where there are insufficient grounds for bringing charges, or the court case is withdrawn, there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It will be made clear to the police that any evidence they provide and is used in the Trust's case, must be made available to the practitioner concerned. Where charges are dropped, the presumption is that the practitioner will be reinstated.

6.0 Restriction of Practice and Exclusion from Work

6.1 Managing the Risk to Patients

When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean will be involved as soon as possible.

Under this Policy, the following guiding principles will always apply:

- Exclusion of clinical staff from the workplace is a temporary expedient whilst action to resolve a problem is being considered.
- Exclusion is viewed as a precautionary measure and not a disciplinary sanction.
- Exclusion from work will be reserved for only in the most exceptional of circumstances.

The Trust will take every measure to ensure 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. No practitioner will be excluded from work other than through this procedure. Informal exclusions of whatever type will not be used.

The purpose of exclusion is to:

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

6.2 Restriction of Practice

The Trust will always consider whether risks may be managed by restricting the practice of the individual concerned, rather than resorting to exclusion. Where

this is appropriate, the degree to which practice is restricted will be determined by the particular circumstances of each case. Ways in which risks may be managed by restricting practice might include:

- Medical or Clinical Director supervision of normal contractual clinical duties;
- restricting the practitioner to certain forms of clinical duties;
- restricting activities to administrative, research/audit, teaching and other educational duties (by mutual agreement, this might include some formal retraining or re-skilling);
- Sick leave for the investigation of specific health problems.

6.3 Immediate Restriction:

In the rare event that **immediate restriction** is necessary, this will be determined and actioned by the AMD concerned or a nominated representative, and sanctioned by a member of the executive team. Where, following formal investigation, a restriction of practice is recommended, within two weeks the nature of this restriction will be determined by the Case Manager.

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The Case Investigator will explore and report on the circumstances that led to the need to exclude the practitioner.

The Medical Director will act as the Case Manager in the case of consultant staff, or delegate to a senior manager to oversee the case, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member.

The Case Investigator will also provide factual information to assist the Case Manager in reviewing the need for exclusion and in making progress reports to the Chief Executive and Designated Board Member. The practitioner will always be notified, in writing, of the degree to which their practice is to be restricted, the means by which the restriction will be managed, and the reasons for this action being taken. All restrictions of practice will be registered with the Medical Director, and will be subject to the same review procedure that is associated with the exclusion process (see below).

6.4 The Exclusion Process

Key features of Exclusion from Work are as follows:

- An initial "immediate" exclusion of no more than two weeks if warranted;
- Notification of the NCAS before formal exclusion;

- Formal exclusion (if necessary) for periods up to four weeks;
- Advice on the case management plan from the NCAS;
- Appointment of a Board member to monitor the exclusion and subsequent action;
- Referral to NCAS for formal assessment, if part of case management plan;
- Active review 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 performance assessment.

Where exclusion, rather than restricting practice, is deemed an essential course of action, the Trust 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 exclusion procedures, key officers and the Board have responsibilities for ensuring the process is carried out quickly and fairly, kept under review, and that the total period of exclusion is not unnecessarily prolonged.

6.5 Persons involved

The **Chief Executive** has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. Therefore, before a decision is taken to exclude a practitioner, the reasons for exclusion will be discussed fully with the **Chief Executive, Medical Director, HR Director** or their nominated representatives, the NCAS and other interested parties (such as the police where there are serious criminal allegations, or the Counter Fraud and Security Management Service). In the rare cases where immediate exclusion is required (see below), the Medical Director and HR Director, or their nominated representatives, must discuss the case at the earliest opportunity following exclusion, by means of a case conference.

For immediate exclusions, the authority to exclude a practitioner at consultant level is vested in the Chief Executive, Medical Director, HR Director, or other member of the Executive Team, only. For staff below consultant level, **DCDs** and **CDs** have the authority to exclude. For staff in training grades, the Director of Postgraduate Medical and Dental Education has the authority to exclude.

~~6.3.1~~ Where the decision to exclude a practitioner arises from an investigatory process, the **Investigating Officer** will provide factual information to assist the **Case Manager** in reviewing the need for exclusion and in making reports on progress to the Chief Executive or **Designated Board Member**.

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The Designated Board Member (see Management Instructions and Guidance, at **Appendix 2**) will ensure that time frames for investigation and/or exclusion are adhered to.

6.6 Immediate Exclusion

In exceptional circumstances, an immediate time-limited exclusion of no more than two weeks may be necessary, for the following reasons:

- to protect the interests of patients, the practitioner or other staff;
- following ☐ a critical incident when serious allegations have been made;
- where there has been a serious breakdown in relationships between a colleague and the rest of the team;
- where the presence of the practitioner is likely to hinder an investigation.

Such an exclusion will allow a more measured and dispassionate consideration to be undertaken, following an incident. This 'breathing space' will be used to carry out a preliminary situation analysis, to contact the NCAS for advice and to convene a case conference. The person making the immediate exclusion (i.e. **Chief Executive, Medical Director, HR Director, Executive Director, DCD, CD or Director of Postgraduate Medical and Dental Education**), must explain to the practitioner:

- in broad terms, why there is a need to make an immediate exclusion (there may be no formal allegation at this stage);
- that they will be informed, at the earliest opportunity, when they will be called back to attend a further meeting: This will be at the earliest opportunity, but in any case, no longer than one working week following immediate exclusion, at which time the practitioner will be notified of the precise nature of the allegation, including specific incidents, dates, persons involved, etc.);
- that immediate exclusion in no way amounts to disciplinary action.

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6.7 Formal Exclusion

No practitioner will be excluded from work, other than through a formal procedure. No 'informal' exclusions, of whatever type, will be invoked by the Trust. A formal exclusion may only take place after the Case Manager has first considered, at a case conference, involving the Medical Director, HR Director and Designated Board Member, whether there is a reasonable and proper case to exclude.

The NCAS must always be consulted, by the Case Manager, where the intention is to invoke formal exclusion, following which the appropriate CD or DCD, Medical Director and/or HR Director will be responsible for informing the practitioner of the exclusion. This action will be taken via a formal meeting, at which:

- the practitioner may be accompanied by a companion (see 5.2.13, above);
- the CD/DCD or Medical Director will have an HR colleague present who may be the HR Director, as an independent witness;
- the precise nature of the allegations or areas of concern will be conveyed to the practitioner;
- the practitioner will be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case;
- the practitioner will 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).

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The formal exclusion will be confirmed in writing, as soon as is reasonably practicable. This confirmation will state the effective date and time; duration (up to 4 weeks); the content of the allegations; the terms of the exclusion (e.g. total exclusion from the premises - see **Management Instructions and Guidance, at Appendix 2** - or exclusion from a particular place of work); the need to remain available for work, and that a full investigation (or what other action) will follow. The practitioner will be advised that they may make representations about the exclusion to the Designated Board Member at any time after receipt of the letter confirming the exclusion.

In cases where disciplinary procedures are being followed, and where a return to work is considered inappropriate, exclusion may be extended for four-week renewable periods. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, as soon as the original reasons for exclusion no longer apply.

If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of their control (for example because of a police investigation), the case must be referred to the NCAS, who will advise whether the case is being handled in the most effective way and suggest possible ways forward. However, even during this prolonged period, the principle of four-week 'renewability' will be adhered to.

If, at any time after the practitioner has been excluded from work, 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, inform the Strategic Health Authority, and make arrangements for the practitioner to return to work with any appropriate support, as soon as practicable.

6.4 Keeping Exclusions under Review

Informing the Trust Board

The Trust Board will be informed of an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed, and will therefore:

- require a summary report of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed, and that all reasonable efforts are being made to bring the situation to an end as quickly as possible. The Case Manager is responsible for providing such reports to the Board, via the HR Director;
- receive a monthly statistical summary showing all exclusions, with their duration and number of times the exclusion has been reviewed and extended (a copy will also be sent to the Strategic Health Authority). The HR Director is responsible for this activity.

Regular review

The Case Manager will review the exclusion before the end of each exclusion period (which may be up to four weeks each), and report the outcome to the Chief Executive and Trust Board. This report is advisory and it is for the Case Manager to decide on the next steps, as appropriate. The exclusion should be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The Trust must take review action before the end of each four-week period: Otherwise, on expiry of the four-week period, the exclusion will lapse and the practitioner will be entitled to return to work. Following three successive four-week exclusion periods, the NCAS must be called in.

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The review activities that will be undertaken at different stages of exclusion are as follows (see below):

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 situation: ▪ The Case Manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time. ▪ Case Manager submits advisory report of outcome to the HR Director and Medical Director. ▪ Each renewal is a formal matter and must be documented as such: The practitioner must be sent written notification on each occasion. The HR Director or Divisional HR Manager is responsible for ensuring these actions are completed.
Third Review	If the practitioner has been excluded for three periods: ▪ The Case Manager submits a situation report to the Chief Executive, 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 Chief Executive must then report to the Strategic Health Authority (SHA) and the Designated Board Member (see Management Instructions and Guidelines, at Appendix 2). ▪ The case must formally be referred to the NCAS, explaining: - why continued exclusion is appropriate; - what steps are being taken to conclude the exclusion at the earliest opportunity. The NCAS will review the case with the SHA and advise the Trust on the handling of the case until it is concluded.

6 Months Review N.B: Normally there will be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned, and where the investigation is lengthy. The Trust and the NCAS will actively review such cases at least every 6 months.	If the exclusion has been extended over six months: ▪ The Chief Executive submits a further situation report to the SHA indicating: - the reason for continuing the exclusion; - the anticipated time scale for completing the process; - the actual and anticipated final costs of the exclusion. ▪ The SHA will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any practical advice to be offered to the Trust Board.

6.8 Review

Where a practitioner considers that a decision to exclude or restrict practice has been applied unfairly, or that there are other reasonable alternatives to exclusion, then the practitioner may apply to have their reasons considered and determined at a meeting of the Review Committee (see paragraph 5.2.14). Such a referral may only proceed with the agreement of the Medical Director and LNC Chair.

7.0 Procedures for Dealing with Issues of Capability

Wherever possible, the Trust will aim to resolve issues of Capability (including clinical competence and health) through ongoing assessment and support, which might include counselling and/or re-training. The NCAS has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and will always be consulted by the Case Manager. Any concerns about Capability relating to a doctor or dentist in a recognised training grade will be considered initially as a training issue and dealt with via the Director of Postgraduate Medical Training and college or clinical tutor, with close involvement of the Postgraduate Dean from the outset.

Capability may be affected by ill-health. Procedures for handling concerns about a practitioner's health are detailed in **Section 5** of this policy.

The Trust will ensure that investigations and Capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability, age or indeed on other grounds. Case Managers and Investigators will receive appropriate and effective training in the operation of Capability procedures. Those undertaking investigations or sitting on Capability or appeals panels will have received formal equal opportunities training before undertaking such duties.

Capability Procedure

Further to the decision taken at Stage 5 of 'Procedure When a Concern Arises':

The Pre-hearing Process

When a report of the investigation has been submitted by the Case Investigator, the Case Manager will give the practitioner the opportunity to comment in writing on the factual content of the report. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in particularly complex cases or due to annual leave, the deadline for comments from the practitioner will be extended.

The Case Manager will decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. Notwithstanding that such actions may already have been taken, the Case Manager will consider urgently:

- whether action under **Section 2** of this policy is necessary to exclude the practitioner; or
- temporary restrictions should be placed on the practitioner's clinical duties.

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The Case Manager will again consider, with the Medical Director and HR Director, whether the issues of Capability can be resolved through local action (such as re-training, counselling, performance review). If this action is not practicable for any reason, the matter must be referred to the NCAS for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The Case Manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments. The NCAS will assist the Trust to draw up an action plan designed to enable the practitioner to remedy any lack of Capability that has been identified during the assessment. The Trust will facilitate the action plan (which has to be jointly agreed by the Trust and the practitioner before it is actioned).

There may be occasion when a case has been considered by the 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 issue should be considered by a Capability Panel (CaP), in which case a hearing will be necessary. If the practitioner does not agree to the case being referred to the NCAS, in the first instance, again a panel hearing will normally be necessary.

The following procedure will be followed prior to a Capability hearing:

- The Case Manager will notify the practitioner in writing of the decision to arrange a Capability 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 Capability 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 choose.
- Wherever practicable, 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 Trust will consider whether a new date should be set for the hearing.
- Should either party request a postponement to the hearing, the Case Manager will be responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not normally less than 30 working days), to proceed with the hearing in the practitioner's absence: The Trust will always act reasonably in deciding to do so.
- Should the practitioner's ill-health prevent the hearing taking place, the Trust's usual sickness absence procedures will be invoked (in accordance with the Staff Policy Framework). The sickness absence procedures take precedence over the Capability procedures and the Trust will take reasonable steps to give the employee time to recover and attend a hearing. Where the practitioner's illness exceeds 4 weeks, they will be referred to the Occupational Health Service. The Occupational Health Service will advise the Trust on the expected duration of the illness and any consequences it may have for the Capability process.
- If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the

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practitioner should have the opportunity to submit written submissions and/or have a representative attend in their absence.

- Witnesses who have made written statements at the investigation stage may, but will not necessarily, be required to attend the Capability hearing. Following representations from either side contesting a witness statement that is to be relied upon in the hearing, the Chairman may 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 will 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 required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

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1.1 The Hearing Framework

- 1.1.1 The CaP will normally be chaired by an Executive Director of the Trust. In addition to the Chair, the Panel will comprise a total of three people; normally two members of the Trust Board, or a senior members of staff appointed by the Board for the purpose of the hearing. The third member will be a medical or dental practitioner not employed by the Trust. The Panel will also be advised by a senior HR representative, nominated by the HR Director (whose main role will be to ensure that due process is followed, throughout) and by a senior clinician agreed with the LNC from the same speciality as the practitioner concerned, but from another NHS employer. As far as is reasonably possible or practicable, no member of the Panel or adviser to the Panel should have been previously involved in the investigation. Membership of the Panel will be agreed with the LNC.

NB: 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 senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

- 1.1.2 Whilst it is for the Trust to decide on the membership of the Panel, the practitioner may raise an objection to the choice of any Panel member, within 5 working days of notification. The Trust will then

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 Trust will provide the practitioner with the reasons for reaching its decision, in writing, before the hearing takes place.

Representation at Capability Hearings

- 1.1.3 The hearing is not a court of law. Whilst the practitioner will be given every reasonable opportunity to present their case, the hearing will not be conducted in a legalistic or excessively formal manner. The protocol to be followed during the hearing is detailed at paragraph 8.7 of this Section.
- 1.1.4 The practitioner will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. 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.

Decisions

The Panel will have the power to make a range of decisions including the following:

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified time scale, with a written statement of what is required and how it might be achieved (stays on record for 6 months).
- Written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Final written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Termination of contract.

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. For example, there may be matters around the systems and procedures operated by the Trust that the Panel wishes to comment upon.

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A record of oral agreements and written warnings will be retained in the practitioner's personnel file, but will be removed following the specified period.

The decision of the Panel will be communicated to the parties as soon as possible, and normally within 5 working days of the hearing. Because of the potential 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.

The decision will be confirmed in writing to the practitioner. This notification will include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC, or any other external/professional body. The practitioner has the right to appeal against the decision, in accordance with the Appeals Procedure at **Section 4** of this policy.

Protocol to be followed for Capability Hearings

As soon as it has been determined that a Capability Panel (CaP) needs to be formed, the practitioner will be provided with written confirmation of this decision, confirmation of the allegations made against them and details of their rights to be accompanied. As soon as possible, thereafter, and at least 20 working days before the hearing, the practitioner will also be informed of the constitution of the Panel, provided with copies of the Case Manager's report and any associated investigation documentation and any documentation and/or evidence that will be made available to the Panel, including witness statements. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will 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 (normally not in excess of 30 days) while this matter is resolved. The trust will provide the practitioner with the reasons for reaching for reaching its decision in writing before the hearing takes place.

The Panel's appointed HR representative will act as the Panel Co-ordinator, who is responsible for the administrative aspects relating to the hearing. The Panel Co-ordinator will write to the practitioner to confirm the date and venue set for the hearing, and to request that any written evidence the practitioner wishes to present at the hearing, including witness statements, are submitted at least three working days before that date. The practitioner may invite witnesses to attend the hearing, if they so wish. The Panel Co-ordinator will confirm that everyone involved with the hearing is available to attend, and inform all parties of any necessary changes to the administrative arrangements.

Once the Panel, the practitioner and their representative are assembled, the Chair of the Panel is responsible for managing the hearing, and ensuring the following protocol is followed:

- Chair introduces those present, summarises why the hearing has been convened, and explains how the hearing will be conducted.

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- Chair explains that the Panel Co-ordinator will make a written record of the proceedings.
- Chair calls the Case Manager or the Trust's representative to present the case against the practitioner. Case Manager will provide documentary evidence and call witnesses, as appropriate.
- Practitioner and their representative are given the opportunity to ask any questions of the Case Manager and witnesses.
- Panel members are invited to ask questions of the Case Manager and witnesses.
- Practitioner and/or their representative are invited to present their case, and to provide any documentary evidence and call witnesses, as appropriate.
- Case Manager, or the Trust's representative, is given the opportunity to ask questions of the practitioner, their representative, and witnesses.
- Panel members are invited to ask questions of the practitioner, their representative and witnesses.
- Chair may ask questions of either party, and ask for points of clarification.
- Case Manager, or the Trust's representative, is asked to sum up.
- Practitioner, or their representative, is asked to sum up.
- Both parties are asked to leave the hearing, whilst the Panel members confer in private, but to be available to return should the Panel need clarify any points of uncertainty.
- Panel makes its decision and both parties are recalled to be informed, by the Chair, of that decision.
- Where the Panel has determined that there is a proven Capability issue, the practitioner is informed of the disciplinary/administrative action to be taken against them. The practitioner is informed of their right to appeal against the Panel's decision.

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Witnesses will be admitted only to give their evidence and answer any questions, and will then retire. The procedure for dealing with any witnesses attending the hearing will be the same and reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;

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- the side calling the witness may question the witness;
- the other side may then question the witness;
- the Panel may question the witness;
- the side that called the witness may seek to clarify any points that have arisen during questioning but may not at this point raise new evidence.

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Following the hearing, and within three working days, the Panel Coordinator will ensure the practitioner receives written confirmation of the outcome, and of any disciplinary/ administrative action to be taken against them. The practitioner will also be reminded of the Appeals Procedure at **Section 4**, below.

8.0 Appeals Procedure

8.1 Purpose

The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a Panel 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, in arriving at their decision, the Panel acted fairly and reasonably, based upon:

- 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.

The Panel may also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The Panel, however, will not re-hear the entire case.

A dismissed practitioner will, in all cases, be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

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 **Capability 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 will have the power to instruct a new Capability hearing.

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

8.2 The Appeal Panel

The appeal panel will consist of three members, who will 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. Membership will be as follows:

- an independent member (trained in legal aspects of appeals) from an approved pool (as agreed and established by the BMA, BDA and NHS Employers - see Appendix 3), designated Chairman;
- the Trust Chairman (or other Trust Non-Executive Director), who will have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate), who is not employed by the Trust, but agreed by the LNC.

All members will be suitably experienced or trained to be able to participate in an appeal hearing.

The Panel will 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 NHS employer;
- a Senior HR specialist.

It is important the Panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable

to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original hearing. Wherever practicable, the following timetable will apply:

- appeal by written statement to be submitted to the designated appeal point (the HR Director, or their nominated representative) 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.

In all cases, the timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager is responsible for ensuring that extensions are absolutely necessary, and kept to a minimum.

8.3 Powers of the Appeal Panel

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. 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 will 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.

If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it will 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 Conduct/Capability hearing panel.

8.4 Conduct of Appeal Hearing

All parties will be in possession of all documents, including witness statements, from the previous hearing, together with any new evidence.

The appellant will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. Such a representative may be legally qualified but they will not, however, be representing the appellant 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.

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 will briefly sum up. At this stage, no new information may be introduced, however the appellant (or their companion) may make a statement in mitigation.

The Panel, after receiving the views of both parties, will consider and make its decision in private.

8.5 Decision

The decision of the appeal panel will be made in writing to the appellant and copied to the 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 will 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 must be sought in writing from the Chairman of the appeal panel.

8.6 Action following Hearing

Records will be kept, including a report detailing the Capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records will remain confidential and retained in accordance with the Data Protection Act 1998. These records will 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 Employment Tribunal.

9.0 Procedures for Handling Concerns **relating to a Practitioner's** Health

9.1 Introduction

A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress. The underlying principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained, and kept in employment, rather than be lost from the NHS.

5.4 Retaining the Services of Individuals with Health Problems

Wherever possible, the Trust will attempt to continue to employ the practitioner, provided this does not place patients or colleagues at risk². This may involve one or more of the following activities:

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to maintain contact and prevent them from feeling isolated);
- removing the practitioner from certain duties;
- reassignment to a different area of work;
- arranging re-training or adjustments to the practitioner's working environment, with appropriate advice from the NCAS and/or deanery, under reasonable adjustment provision in the Disability Discrimination Act 1995.

At all times, the practitioner will be supported by the Trust and the Occupational Health Service (OHS), who will ensure that the practitioner is offered every available resource to be able to return to practise, where appropriate. The Trust will consider what reasonable adjustments might be made to their workplace conditions, or other arrangements. Examples of reasonable adjustment include:

- making adjustments to the premises;
- re-allocation of some duties to colleagues;
- transfer of the practitioner to an existing vacancy;
- altering the practitioner's working hours, or pattern of work;
- assignment to a different workplace;
- allowing absence for rehabilitation, assessment or treatment;
- provision of additional training or re-training;
- acquiring/modifying equipment;

² *Maintaining High Professional Standards in the Modern HPSS*

- modifying procedures for testing or assessment;
- establishing mentoring arrangements.

In some cases, retirement due to ill-health may be necessary. Ill-health retirement will be approached in a reasonable and considerate manner. However, it is important that the issues relating to conduct or Capability that have arisen are resolved, using the agreed procedures, where appropriate.

9.2 Handling Health Issues

Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine the precise nature of that problem.

In such cases, the Case Manager will immediately refer the practitioner to a consultant occupational health physician within the Trust's OHS. NCAS will also be approached to offer advice on any situation and at any point where the Trust is concerned about a practitioner's health. Even apparently simple or early concerns will be referred, as these are easier to deal with before they escalate.

The Occupational Health physician will agree a course of action with the practitioner and send their recommendations to the Medical Director.

A meeting will then be convened with the HR Director, or their nominated representative, the Medical Director, or their nominated representative, or Case Manager, the practitioner and case worker from the OHS. The purpose of this meeting will be to agree a timetable of action and rehabilitation (where appropriate).

The practitioner may wish to bring a support companion to these meetings, who might be a family member, a colleague or a trade union or defence association representative. Confidentiality will be maintained by all parties, at all times.

If a practitioner's ill-health makes them a danger to patients and they do not recognise that danger, or are not prepared to co-operate with measures to protect patients, then exclusion from work will be considered and the professional regulatory body informed, irrespective of whether or not the practitioner has retired on the grounds of ill-health.

In those cases where there is impairment of performance solely due to ill-health, disciplinary procedures will only be considered in the most exceptional of circumstances, for example if the practitioner refuses to co-operate with the Trust to resolve the underlying situation by repeatedly refusing a referral to the OHS or

the NCAS. In these circumstances, the procedures for dealing with issues of Capability (see Section 3.0) will be followed.

There will be circumstances where a practitioner who is subject to disciplinary proceedings submits a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the practitioner 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.

DRAFT**Managing Poor Performance – Consultant Medical Staff****Southern Health & Social Care Trust (SHSCT)**

1. The SHSCT wish to set out principles which can be applied in relation to the management of poor performance for all Trust staff to minimise potential risk for patients, practitioners, clinical teams and the organisation.
2. One element of this document would specifically describe Trust guidance concerning Consultant Medical Staff (including Associate Specialist grades) and would be based on external best practice guidance including
"How to conduct a local performance investigation" NCAS, 2010
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005
3. This guidance will also seek to take account of the new role of the Responsible Officer which Trust's in Northern Ireland must have in place by October 2010. The interfaces between this role and the management of poor medical performance must be considered and defined (NCAS, 2010)
4. Before deciding action is required in relation to poor performance all concerns and reports of potential issues should be screened.
Screening determines whether action, in the form of an investigation, should be taken or not, and if so how this should be done – ie informally or formally
5. MHPS (2005) states:
 - that **all** concerns must be registered with the Chief Executive (CE)
 - An initial verification and assessment of the issues raised should be undertaken by the clinical manager of the practitioner (Clinical Director or Associate Medical Director)
 - This assessment should be presented to decide on whether an informal or formal investigation is required. This is a difficult decision and should not be taken alone but in consultation by key people within the organisation and advice from NCAS and OHS as required.
6. In order to assure and promote fairness, transparency and consistency in approach to the process of performance investigation, and to ensure protection for the Medical Director / Responsible Officer, the SHSCT is proposing that ~~an oversight group (OG) decision-making group (DMG)~~ **is appointed by the Chief Executive, this will normally** comprising of the Medical Director / Responsible Officer, the Director of Human

Resources (DHR as recommended by MHPS, 2005) and the relevant Operational Director (OD) **who will consider the initial verification/assessment by the clinical manager of the practitioner / issue and will** take the decision to investigate or not and whether this is a formal or informal investigation, while taking advice from NCAS or OHS and the clinical line manager. -The case assessment should be presented to them for a decision by the clinical manager. This decision will be ratified by the Chief Executive. SMT Governance Committee cannot be involved in decisions at this point as Executive representation may be required at a Panel Hearing. **Please note: If the initial report / concern is made directly to the medical director (in error) then the medical director cannot be involved in the oversight group nor can they sit on any formal panel hearing. All staff require to be fully briefed as to how to raise an issue of concern re performance.**

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7. NCAS also recommends that no person involved in one stage of an investigation should take part in subsequent disciplinary proceedings or appeals based on the same set of facts. Separation of roles is an important element of securing fair process. (NCAS, 2010) Just need to be clear here that as is written above oversight group are guiding principle of whether informal or formal investigation – is this ok??
Kieran

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8. While the Responsible Officer / Medical Director must discharge his statutory role, this is one of establishing and overseeing the process of initiating investigations into potential poor performance.
9. Where a further investigation is likely to lead to conduct or clinical performance proceedings – ie the Trust invoking their disciplinary procedures and/ or onward referral to the police and / or GMC then a formal investigation process should be followed (See Flow Chart 2)
10. The ~~oversight~~**decision-making** group should first seek, if possible and appropriate, a local action plan agreed with the practitioner and resolution of the situation (NCAS to advise) via monitoring of the practitioner by the Clinical Manager.
11. The various processes involved in managing performance issues are described in a series of flow charts and text. They include in sequence:
- An informal process **[Flow Chart 1]** – this can lead to resolution or move to
 - A formal process **[Flow Chart 2]** – this also can lead to local resolution or to
 - A conduct panel OR a clinical performance panel depending on the nature of the issue **[Appendix 2]**

- An appeal panel can be invoked by the practitioner following a panel determination. **[Appendix 3]**
- Exclusion can be used at each step of the process **[Appendix 4]**

The process moves from informal to formal if NCAS and the organisation agree it is required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAs referral or recommendations.

Please note if any of the above processes are entered into and findings are anything more than the practitioner being exonerated, these findings should be recorded and available to appraisers.

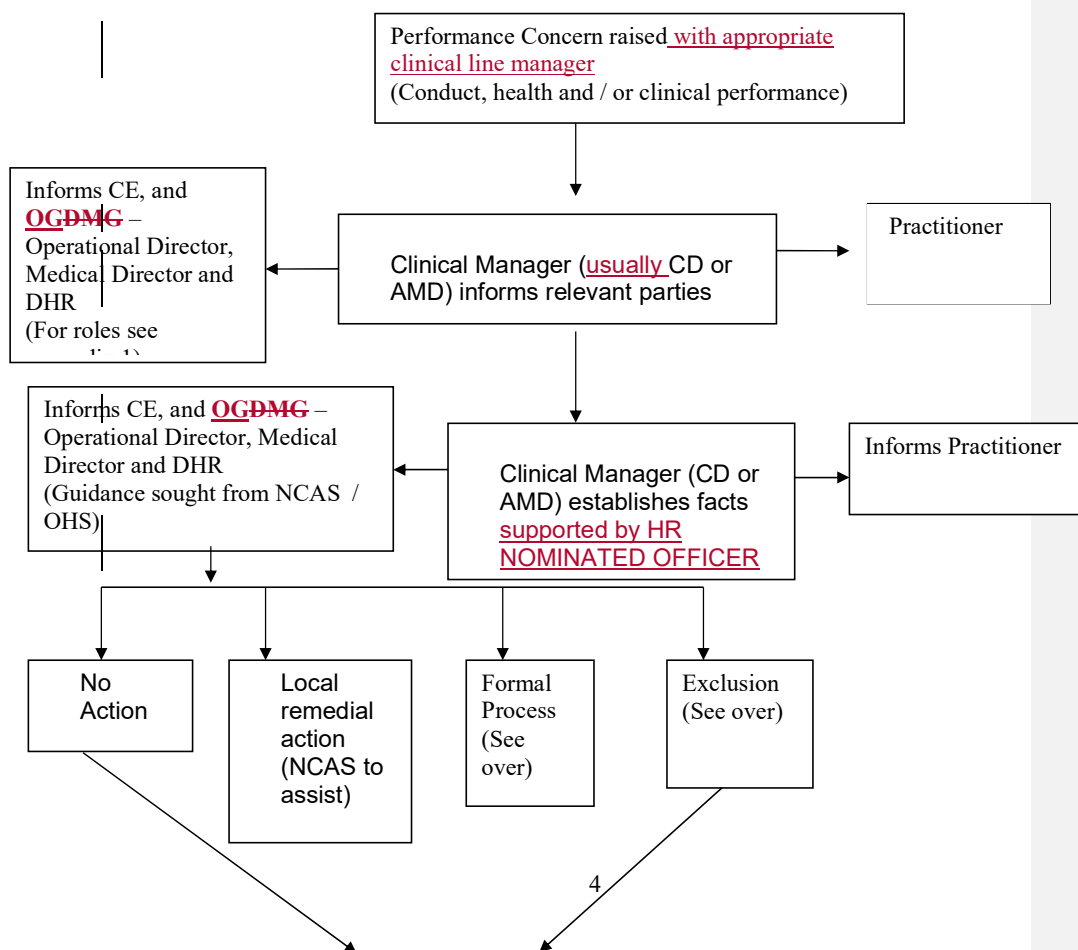
Flow charts and text describe who should be involved when and the timescales involved. The Southern Trust will also present all formal investigation processes to the SMT Governance committee retrospectively post any further panel or appeal, to promote learning and for peer review.

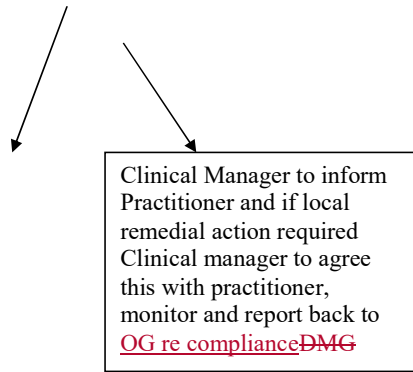
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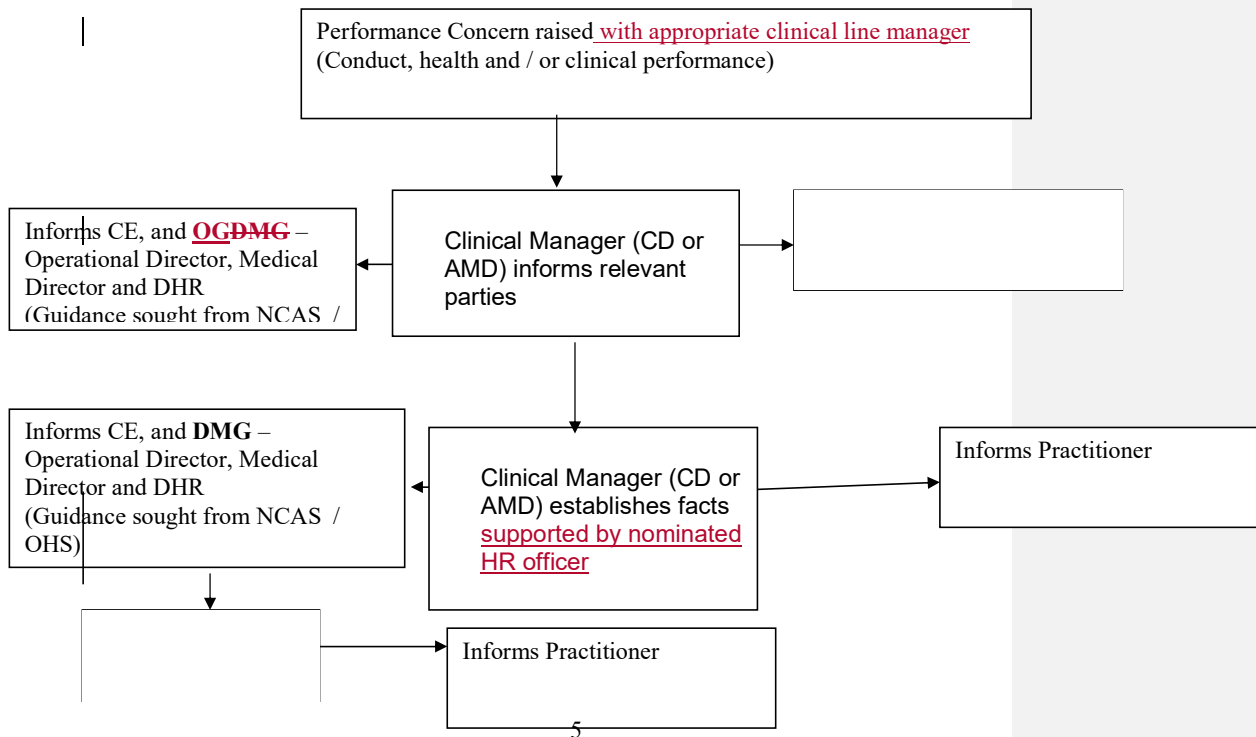
INFORMAL PROCESS - Flow Chart 1

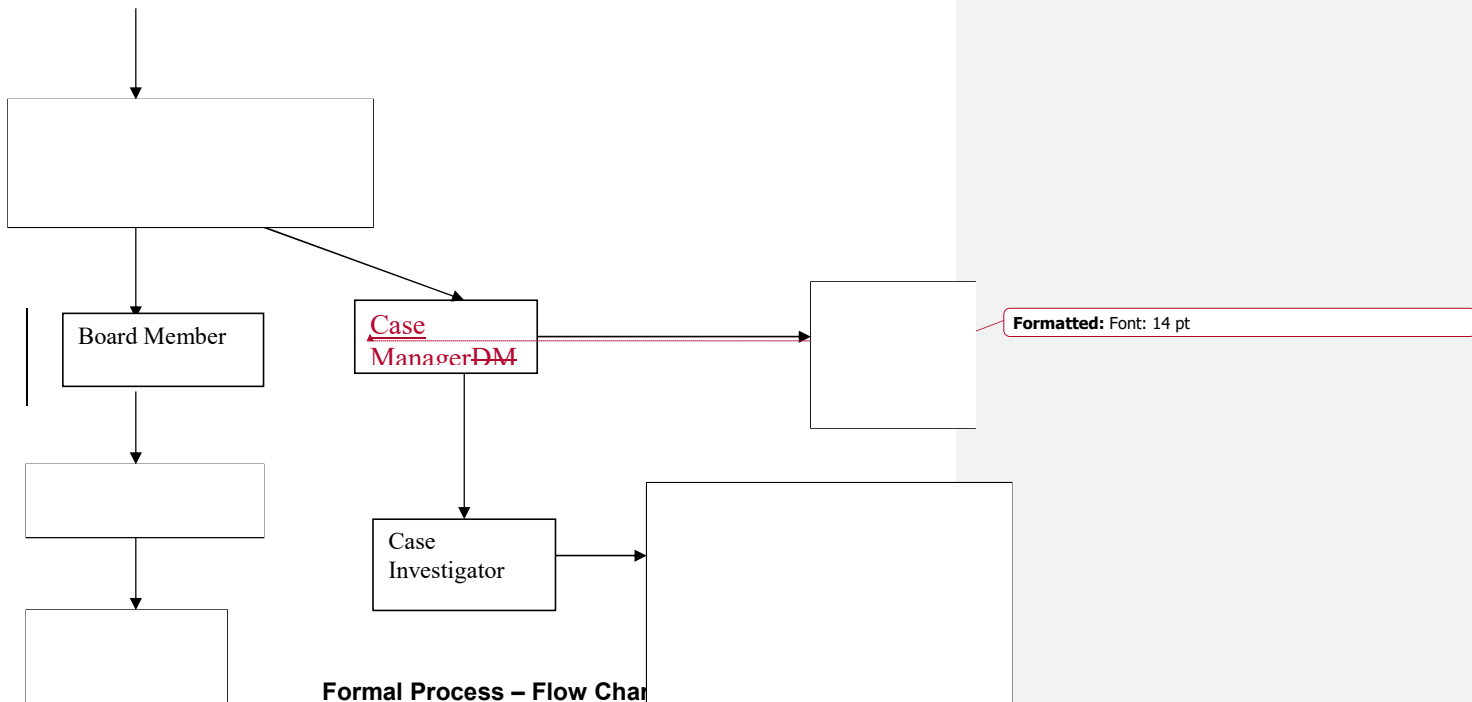




Note: DMG – Decision Making Group (NCAS, 2010)

FORMAL PROCESS - Flow Chart 2

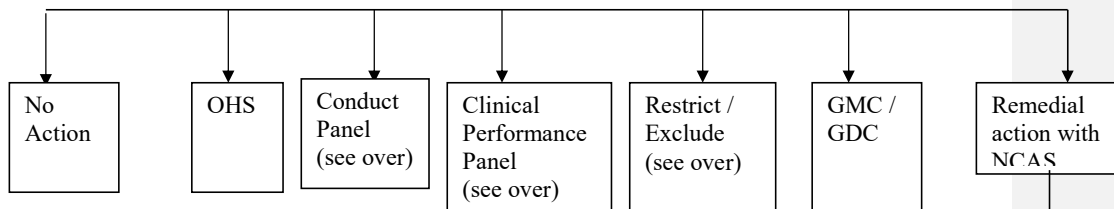




Formal Process – Flow Chart

Case ~~Report~~ Report and recommendations / decisions presented by case manager to OG and CEO. Case manager will receive support from a nominated HR officer and NCAS. Decisions by case manager can be as follows:

OGDMG gives practitioner opportunity to comment



Practitioner informed by Case
Manger~~DMG~~

Clinical Manager to inform
Practitioner if local remedial
action required Clinical
manager to agree this with
practitioner, monitor and
report back to OG re
compliance~~DMG~~

APPENDIX 1

Informal Investigation – Roles

Clinical Manager: AMD or CD (usually CD unless concerns re they themselves) to whom concerns are expressed and who informs Chief Executive and Practitioner, and conducts initial assessment to present to an Oversight group-Decision-Making Group. Conveys to the practitioner the findings of the initial screeningDecision-making-group and monitors any remedial action required.

Chief Executive: Appoints an appropriate oversight groupDecision-Making Group – usually the Medical Director / Responsible Officer, Director of HR and the relevant Service Director. Ratifies the decisions throughout the process of this group.

Oversight GroupDecision-Making Group: Screens initial concerns and decides if informal or formal investigations required.

Formal Investigation – Roles

Chief Executive: Appoints a case manager - usually the AMDdecision-making-group-above. Ratifies the findings of the formal investigation. Appoints a case investigator, usually the CDAMD. Appoints a non executive board member to monitor progress and report findings to the Trust Board.

Case Manager: Usually the AMDdecision-making-group—Medical-Director/ Responsible Officer, Director of HR and the Service Director. Co ordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. They keep all parties informed of the process and they also determine the outcome once the formal investigation has been presented. Should the concerns involve a CD then the case manager becomes the MD – and they can no longer chair or sit on any formal panel hearings. The AMD would be the case investigator in this instance.

Case Investigator: Usually the CDAMD, examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager ~~/DMG~~ in a report format.

Non Executive Board Member: Assures that the investigation is completed in a fair and transparent way, in line with Trust procedures and in a timely way. Reports back findings to Trust Board.

Appendix 2

Conduct Panel

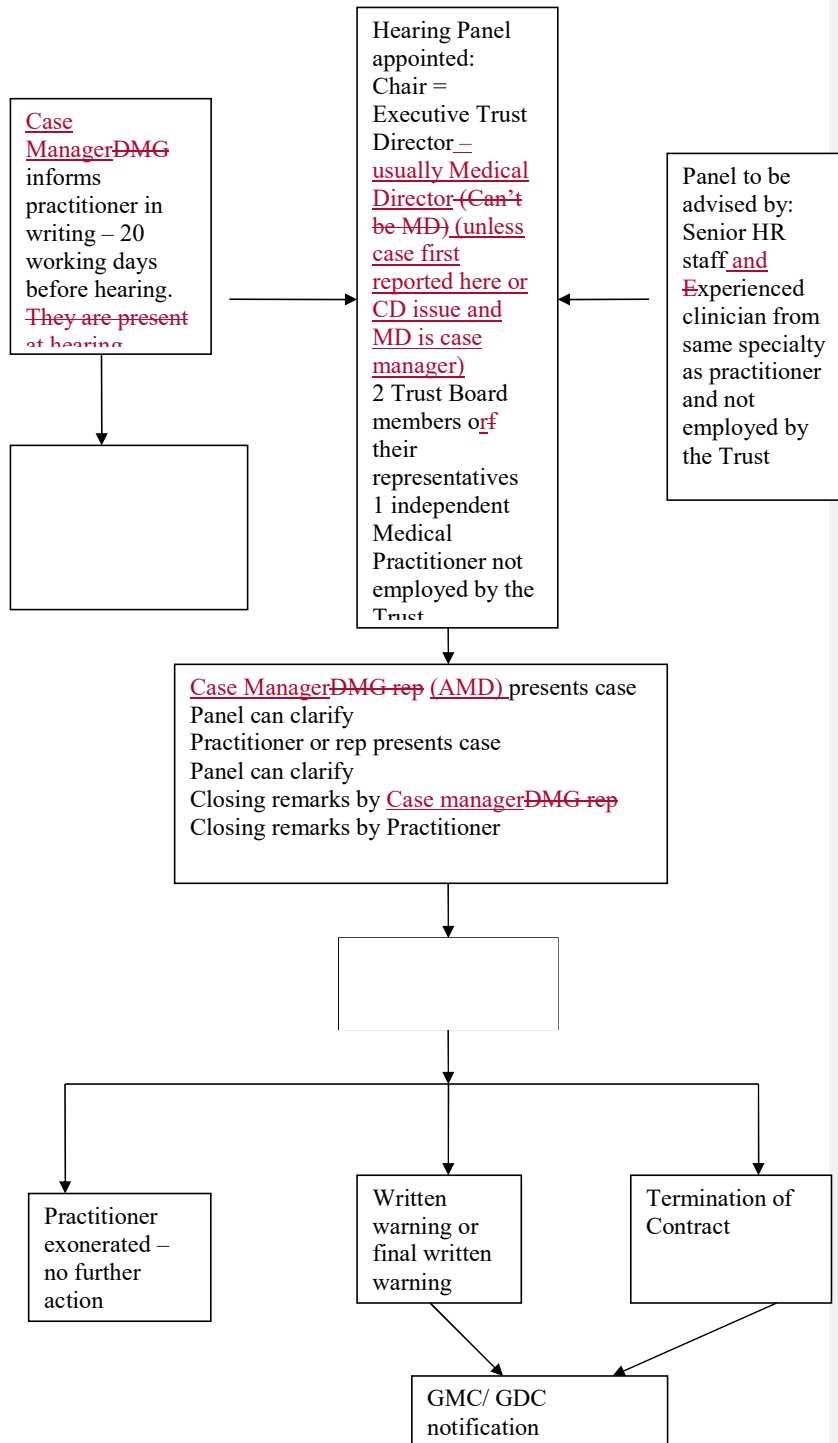
- Applies when the outcome of a **formal investigation** shows a case of misconduct – either personal or professional.
“Misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer’s procedures covering other staff where conduct is in question” MHPS, 2005
- If a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure.
- NCAS should be used in cases of misconduct for advice, particularly in relation to cases of professional misconduct
- *“Examples of misconduct will be found in the Employers Code of Conduct. Examples can include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and / or discrimination in the exercise of duties towards patients, the public or other employees. It can also include actions such as deliberate falsification or fraud.”*
MHPS, 2005
- *“In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC”*
MHPS, 2005

Insert trust procedure with inclusion of independent professional advice - to sit on panel – ie not employed by the Trust – Kieran can you do this bit

Clinical Performance Panel

- Applies when the outcome of a **formal investigation** shows a case of poor clinical performance.
- Failures of an individual to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance are clinical performance issues.
- These include
 - out moded clinical practice
 - inappropriate clinical practice arising from a lack of knowledge or skill that puts patients at risk
 - incompetent clinical practice
 - inappropriate delegation of clinical responsibility
 - inadequate supervision of delegated clinical tasks
 - ineffective clinical team working skills
- NCAS can advise the organisation whether to proceed with a locally agreed remedial action – which will be monitored and reviewed by the clinical manager OR NCAS may advise that the practitioner's performance is so fundamentally flawed that no educational / organisational plan will succeed. In the latter case the Case Manager (AMD)DMG will take a decision as to whether or not to proceed to a clinical performance panel hearing.
- A clinical performance panel hearing will also result if the practitioner fails to agree a referral to NCAS and/or to participate in any remedial plan.

Performance Panel Hearing Process –Flow chart 3



Appendix 3

Appeals Process

- This can be invoked by the practitioner within 25 days of a formal conduct or clinical performance panel determination.
- **Appeal Panel:** An independent member (trained in legal aspects) from an approved pool, who would act as Chair of the panel, Chairperson of the Trust and an independent clinician not employed by the Trust who is trained in the appeals process.
- **Advisors to the Panel:** A clinician from the same specialty as the appellant but not employed by the Trust and a senior HR specialist
- Request for appeal should be received by the DHR within 25 working days of the Panel determination
- Appeal hearing to take place within 25 working days of date of lodging appeal
- Appeal panel to report within 5 working days of the appeal hearing.

Appendix 4

EXCLUSION

- **Immediate exclusion** may be invoked as a temporary measure to
 - Protect the interests of patients or staff
 - Where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care
- Immediate and temporary exclusion periods should be used to carry out a preliminary situation analysis by the clinical manager and for the **OGDMG** to determine a clear course of action – including the need for formal exclusion.
- NCAS must be informed, where possible, prior to the implementation of an immediate exclusion.
- The authority to exclude a member of staff must be vested in a nominated manager(s) of the Trust – including where possible the CE, MD, DHR and for staff of lower grade than a consultant - the AMD. The Clinical Manager seeking an exclusion must make a representation to these officers as there may be no formal allegation at this stage.
- Immediate exclusion must be for the shortest time possible and be no longer than 4 weeks.
- **Formal exclusion** is a precautionary measure and not a disciplinary sanction. It should be reserved for only the most exceptional circumstances:

- 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
- The Trust should ensure that where a practitioner is excluded it is for the minimum necessary period of time – this can be up to but no more than 4 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 to the nominated board member when requested - they are responsible for monitoring the situation until the exclusion has ended.

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Toal, Vivienne

From: Vivienne Toal <[redacted] Personal Information redacted by the USI >
Sent: 11 August 2010 19:58
To: [redacted] Vivienne Toal personal email address
Subject: Fw:
Attachments: handlin_Concerns_policy_4august10.doc

----- Original Message -----

From: Brennan, Anne <[redacted] Personal Information redacted by the USI >
To: Vivienne Toal; Siobhan Hynds; [redacted] D Burns email address
Sent: Wed Aug 11 09:53:49 2010
Subject: FW:

For our meeting today

Anne Brennan

Senior Manager - Medical Directorate

[redacted] Personal Information redacted by the USI

Tel: [redacted] Personal Information redacted by the USI

-----Original Message-----

From: Loughran, Patrick
Sent: 05 August 2010 10:52
To: Brennan, Anne
Subject: FW:

Anne

Attached includes thinking from wed meeting with MMcA, DB,PL and KD,

I have also talked with Grainne from NCAS to run some scenarios past her and this conversation is reflected in the additions I have made.

Can we look at presenting MHPS electronically without any alteration and then inserts in ?shaded boxes to reflect the ST guidance/understanding and proposed practice guidance. Including reference to LPI as a subsid document.

This will leave MHPS untouched as a framework and reference and protect the ST, and the explicit guidance threaded through it is for our staff ??

Talk Mon

Paddy

-----Original Message-----

From: pgloughran [Personal Information redacted by the USI]

Sent: 04 August 2010 23:24

To: Loughran, Patrick

Subject:

Procedure for Handling Concerns about Doctors' and Dentists' Performance

Southern Health and Social Care Trust

Procedure for Handling Concerns about Doctors' & Dentists' Performance

Southern Health and Social Care Trust

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1.0 Background

This procedure is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been developed to reflect the framework set out in HSC2003/012, "Maintaining High Professional Standards in the Modern NHS".

This policy applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust.

This policy and procedure applies to the management of performance and capability issues.

This policy is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been devised to reflect the framework set out in HSC2003/012, "Maintaining High Professional Standards in the Modern NHS".

Its provisions cover action to be taken when a concern about a doctor or dentist first arises and action to consider whether there need to be restrictions placed on a doctor's or dentist's practice or exclusion from work is considered necessary.

The new approach set out in the 'Maintaining High Professional Standards' framework, and which is reflected in this Procedure, builds on four key elements:

- Appraisal and revalidation - processes which encourage practitioners to maintain the skills and knowledge needed for their work through continuing professional development;
- The advisory and assessment services of the National Clinical Assessment Service (NCAS) - aimed at enabling Trusts to handle cases quickly and fairly, and reducing the need to use disciplinary procedures to resolve problems;
- Tackling the blame culture - recognising that most failures in standards of care are caused by systems' weaknesses, and not individuals per se;
- Abandoning the 'suspension culture' - by introducing the new arrangements for handling 'exclusion from work'.

2.0 Purpose

The purpose of this procedure is to:

- Introduce a new approach which recognises the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action
- Establish a clear and co-ordinated process for handling concerns relating to the safety of patients posed by the conduct and/or performance of doctors and dentists, which come to the attention of the Trust. Whatever the source of this information, the response will be the same, i.e. to:
 - Ascertain quickly what has happened and why.
 - Determine whether there is a continuing risk.
 - Decide whether immediate action is needed to remove the source of the risk.
 - Establish actions to address any underlying problem.

The procedure also sets out clear processes, again in accordance with the national framework, for handling disciplinary procedures relating to doctors and dentists. These include dealing with issues of Misconduct and Capability, and handling concerns relating to a practitioner's health.

3.0 Guiding Principles

In the handling of concerns relating to the conduct and performance of doctors and dentists, the following guiding principles will always apply:

Trust recognizes that MHP document contains a framework which must be adhered to. Current document is guidance for the SHSCT staff to follow as it uses the framework. LPI is a subsidiary advisory text – is subservient to MHPS supports MHPS mainly in the informal part of mhps para 15,16 1nd 17

- The Trust recognises that unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore, all allegations, including those made by relatives of patients, or concerns raised by colleagues, will be carefully considered and, if required, properly investigated to verify the facts, such that the allegations may be shown to be true or false.

- The Trust will always endeavour to resolve issues as informally as possible, where such issues are not deemed to be of a serious nature.
- Exclusion from work will be used only in the most exceptional of circumstances, and the exclusion of a practitioner will not be viewed as a solution in itself. Furthermore, periods away from work will be kept to the minimum, through effective performance management arrangements, which will ensure that progress with an investigation is maintained and the need for continued exclusion is frequently reviewed (an exclusion will lapse and the practitioner will be entitled to return to work if the exclusion is not actively reviewed).
- The Trust will consult with the NCAS at an early stage, when action in relation to clinical concerns is being considered, and thereafter on a regular basis whilst a case is progressing. The underlying intention is that the early intervention of the NCAS will help the Trust to maintain momentum in resolving concerns about clinical competence, and thereby reduce the number of doctors and dentists who are excluded from their workplace for long periods of time.
- The Trust will work with the NCAS to ensure that, wherever possible, alternatives to exclusion are considered.
- Concerns relating to the Capability of doctors and dentists in training should be considered as training issues, and the Trust's Associate Medical Director of Medical Education & Training will be involved from the outset. The training agency will also be informed at the outset
- The Trust supports an open approach to reporting and tackling concerns about doctors' and dentists' practice, and recognizes the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action.
- The Trust will maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Trust will only confirm that an investigation or disciplinary hearing is underway.

4.0 Procedures when a Concern Arises

4.1 Identification of potential performance issues

Concerns regarding a doctor or dentist's performance can be flagged by a number of formal or informal sources, such as:

- Colleagues or students
- During job planning, appraisal or revalidation processes
- Monitoring of quality or performance data
- Quality improvement activities, such as clinical audit
- Complaints from patients & relatives
- Information from the General Medical Council (GMC), General Dental Council (GDC) or other regulatory bodies
- Litigation following allegations of negligence
- Information from police or coroner
- Court judgements

4.2 Stage 1 - Action when a Concern Arises

When a concern arises, relating to a particular doctor or dentist, the following procedures will be followed: These procedures will allow for informal resolution of less serious problems

The matter will be brought to the attention of the appropriate Clinical Director (CD), or their elected deputy, at the earliest possible opportunity. Should the matter relate to the conduct or performance of a CD, then the Associate Medical Director (AMD) must be informed. The CD/AMD will then inform the Operational Director and Medical Director of the nature of the concern.

All serious concerns must also be registered with the Director of Human Resources and Organisational Development and Chief Executive. The service director and the MD along with the two above will be known as the oversight group. The duty of the oversight group is to see that the process described in the MHP progress in a timely and fair manner and to ensure the Trust keeps the investigation process separate from the decision making process

By strict adherence to the above insulation of the MD and only allowing the MD to have limited knowledge/facts of the case – only those facts which are needed for oversight then the MD will be free and able to act later, if needed, in a conduct or clinical panel

The duty to protect patients is paramount. When a serious concern is raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. **Section XX** of this document sets out the procedures for this action.

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4.3 Stage 2 - Assess the type and potential seriousness of the issue & whether full formal investigation is required.

On behalf of the Chief Executive, the Medical Director, or nominated representative, in consultation with the HR Director, or nominated representative, will appoint a senior clinician to act as '**Case Manager**' to assess the type and potential seriousness of the issue and provide information on whether a full formal investigation is required.

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The med dir should refrain from learning any more than a minimum amount of detail about the issue – enough only to allow a decision to be reached about the need for the next step or otherwise

While the MHPS document para xxxxx states that the md is usually the CM the st has a layer of senior doctors who discharge a governance role – “the AMD”
. If an appropriate AMD is trained and available to act as the case manager then on a case by case basis the AMD may be nominated to replace the MD as a CM

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This senior clinician will be appropriately experienced or trained to enable them to carry out this role when required. The Medical Director, or Associate Medical Director, or appointed representative, will act as Case Manager in cases involving Clinical Directors.

Where there are concerns about a doctor or dentist in training, the Postgraduate Dean and the Director of Medical Education and Training will be informed as soon as possible.

A decision to investigate commits the organization to significant work and expense, so the organization needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

The Trust supports a 'Screening' process using the NCAS 'How to Conduct a Local Performance Investigation' framework to identify whether a formal investigation is needed.

Anonymous complaints or concerns based on 'soft' information should be put through the same screening process as other concerns.

4.3.1 What should be considered in making a decision to investigate?

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

The appointed Case Manager or the Service Director should contact have a preliminary meeting with the doctor/dentist, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses. At this point the case manager should avoid an exchange which might be construed as gathering information/evidence, since the is the duty of the Case Investigator

A short note of the contents of this meeting must be made and agreed by both parties

The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police advise that early meetings or early disclosure could compromise subsequent investigations.

Formal Investigation will usually be appropriate where case information gathered to date suggests that the doctor may:

- Pose a threat or potential threat to patient safety or the index concern is very serious [eg a death or serious loss of a vital function to a patient]
- Expose services to financial or other substantial risk;
- Undermine the reputation of efficiency of services in some significant way;
- Work outside acceptable practice guidelines and standards
- The initial contact with the doctor gives a strong indication that informal resolution will be impossible

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4.3.2 What Alternatives to Full Investigation are Available?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;

- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the following circumstances:

- The practitioner may agree that the concerns are well-founded and agree to cooperate with required further action. However, if the issues raised are serious enough to suggest that if upheld they might warrant consideration of termination of employment or removal from a performers list, then the organisation may still need to conduct an investigation. The action to be taken subsequently would then be decided in the normal manner.

Defining the seriousness of an issue is by no means always an easy decision, and the advice of the Medical Director and the Director of Human Resources (or a nominated member of the senior HR team) should be sought. Advice from the NCAS may be sought in cases of professional misconduct or capability.

The Case Manager will explore the potential problem with the NCAS to consider different ways of addressing it themselves. In so doing, the Case Manager may possibly recognise the problem as being more to do with work systems than the practitioner's performance, or see a wider problem needing the involvement of an outside body, other than the NCAS.

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The role of the NCAS, and the responsibility of the Trust and individual practitioners towards the NCAS, are detailed in the Management Instructions and Guidelines, at **Appendix 1**.

The Case Manager will not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analysis of adverse events should be conducted as these frequently show that causes 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. The National Patient Safety Agency (NPSA) facilitates the development of an open and fair culture, which encourages doctors and dentists and other NHS staff to report adverse incidents and other near misses and the Case Manager will consider contacting the NPSA for advice about systems or organisational failures.

The decision will be taken following consultation with the Medical Director and HR Director, or their nominated representatives, and NCAS.

Where an informal route is chosen the NCAS will remain involved until the problem is resolved.

Having discussed the case with the NCAS and/or NPSA, the Case Manager must decide whether:

- there is no case to answer; or
- the issue is one that should be resolved through an informal approach; or
- the issue is such that a formal investigation is needed.

Where the issue is clearly one of alleged Misconduct or gross Misconduct, due to factors other than those directly involving the exercise of medical and dental duties (e.g. bullying; assault; theft; fraud; failure to fulfill contractual obligations; refusal to comply with the reasonable requirements of the Trust; non-attendance at work; the commission of criminal offences outside the place of work which may, in particular circumstances, amount to Misconduct or gross Misconduct), such issues will be handled under the **Trust Disciplinary Policy**, within the Staff Policy Framework, which applies to all staff.

The procedures associated with the Trust Disciplinary Policy require that a full and thorough investigation is conducted. The Case Manager and HR Manager, or their nominated representatives, are responsible for ensuring these procedures are correctly followed, and the practitioner is kept properly informed about the details of the allegations and the process. The practitioner will also be advised whether the alleged offence amounts to gross Misconduct, which if proven may lead to summary dismissal;

Where the issue involves the exercise of medical and dental duties, or where the nature of the issue is such that the **Case Manager** determines it may lead to either Misconduct or Capability proceedings, the Medical Director will, after discussion between the Chief Executive and Director of Human resources or their nominated representative, appoint an appropriately experienced or trained person as '**Case Investigator**'. The seniority of the Case Investigator will differ, depending on the grade of practitioner involved in the allegation. Several clinical managers will be appropriately trained, to enable them to carry out this role as required.

The Case Investigator is responsible for leading the investigation into the concerns about the practitioner, establishing the facts, and reporting the findings. The role of the Case Investigator is detailed in the Management Instructions and Guidelines, at Appendix 1.

4.4 Stage 4 Investigation:

When it is decided that a formal approach needs to be following the CX, etc appoint a Case Manager, Case Investigations

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As soon as the decision has been taken to commission an investigation, the Case Manager will inform the practitioner, in writing, of the name of the Case Investigator, and of the specific concerns/allegations that have been raised against them (this information will be as comprehensive as possible, in terms of incidents, dates, persons involved, etc.). The practitioner will also be given the opportunity, as early as is reasonably practicable, to see any correspondence relating to the case, together with a list of the individuals the Case Investigator intends to interview. The practitioner will be able to add to this list if important witnesses are not scheduled to be interviewed.

The practitioner will be afforded the opportunity to put their view of events to the Case Investigator and informed of their right, at any stage of this process (or subsequent disciplinary action) to be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. The companion may be legally qualified, but they will not be acting in a legal capacity.

If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the Case Manager should consider whether an independent practitioner from another NHS body should be invited to assist.

The Case Investigator should complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 days.

The Case Manager will review the report and, through further consultation with an internal Review Committee, Anne this needs to be discussed as the yielding of too much info to others at this stage will contaminate for example the MD ---why can we not allow the CM who is senior and trained and who will be well supported by a AD in HR to make a recommendation para 38 page 12..... determine whether, or not, there is a case to answer and what action should be taken.

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The Review Committee will consist of the Case Manager; Medical Director; HR Director, and the LNC Chair, or their nominated representatives. The NCAS will also be invited to attend. Where it is determined that there is a case to answer, the Case Manager, in consultation with the Review Committee and NCAS, will consider whether restrictions on practice or exclusion from work should be

considered, notwithstanding that this action may already have been taken (see procedures at Section 2).

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The Case Investigator has no involvement in actual decisions made for action to be taken in the case and must not be a member of any disciplinary panel.

4.5 Stage 5 Outcome of investigation

The Case Manager will review the investigation report and make a decision with regards to the way forward. At this stage, it should be decided if the issue is one of **conduct** or one of **capability**:

- **Conduct** – the behaviour of the doctor or dentist is the source of concern. This can include failure or refusal to comply with trust standards. Where an investigation identifies issues of professional misconduct¹ as opposed to personal, the Case Investigator should additionally seek professional advice from a doctor or dentist employed in the same speciality (who has not been involved with the case)

All forms of misconduct should be dealt with under the trust's Disciplinary Procedure

- **Capability** – the ability of the doctor or dentist to perform particular aspects of their role is in question. This is demonstrated by a clear failure by an individual to deliver an adequate standard of care, or standard of management or clinical practice, through lack of knowledge, ability or consistently poor performance.

Inevitably, some cases will involve both Misconduct and Capability issues. These cases are likely to be complex and difficult to manage. Therefore, where a case covers more than one category of problem, they will usually be combined and considered under a Capability hearing. However, there may be occasions where it is necessary to pursue a Misconduct issue and a Capability issue separately. In these difficult cases, the Case Manager, in consultation with the NCAS and the Trust's own employment law advisers, will recommend the most appropriate course of action.

■ ¹ Professional misconduct is defined as actions or behaviour that do not comply with standards of professional behaviour laid down by professional regulatory bodies or failure to comply with the trust's clinical policies.

5.0 Action when an Investigation identifies possible Criminal Acts

Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The Trust investigation (under either its Misconduct or Capability Procedure) will only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The Trust will consult the police to establish whether an investigation into any other matters would impede their investigation.

5.1 Cases where Criminal Charges are brought, not connected with an Investigation

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

5.2 Dropping of Charges or no Court Conviction

When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but it is considered there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to eliminate this risk. Similarly, where there are insufficient grounds for bringing charges, or the court case is withdrawn, there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It will be made clear to the police that any evidence they provide and is used in the Trust's case, must be made available to the practitioner concerned. Where charges are dropped, the presumption is that the practitioner will be reinstated.

6.0 Restriction of Practice and Exclusion from Work

6.1 Managing the Risk to Patients

When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean will be involved as soon as possible.

Under this Policy, the following guiding principles will always apply:

- Exclusion of clinical staff from the workplace is a temporary expedient whilst action to resolve a problem is being considered.
- Exclusion is viewed as a precautionary measure and not a disciplinary sanction.
- Exclusion from work will be reserved for only in the most exceptional of circumstances.

The Trust will take every measure to ensure 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. No practitioner will be excluded from work other than through this procedure. Informal exclusions of whatever type will not be used.

The purpose of exclusion is to:

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

6.2 Restriction of Practice

The Trust will always consider whether risks may be managed by restricting the practice of the individual concerned, rather than resorting to exclusion. Where

this is appropriate, the degree to which practice is restricted will be determined by the particular circumstances of each case. Ways in which risks may be managed by restricting practice might include:

- Medical or Clinical Director supervision of normal contractual clinical duties;
- restricting the practitioner to certain forms of clinical duties;
- restricting activities to administrative, research/audit, teaching and other educational duties (by mutual agreement, this might include some formal retraining or re-skilling);
- Sick leave for the investigation of specific health problems.

6.3 Immediate Restriction:

In the rare event that **immediate restriction** is necessary, this will be determined and actioned by the AMD concerned or a nominated representative, and sanctioned by a member of the executive team. Where, following formal investigation, a restriction of practice is recommended, within two weeks the nature of this restriction will be determined by the Case Manager.

The Case Investigator will explore and report on the circumstances that led to the need to exclude the practitioner.

The Medical Director will act as the Case Manager in the case of consultant staff, or delegate to a senior manager to oversee the case, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member.

The Case Investigator will also provide factual information to assist the Case Manager in reviewing the need for exclusion and in making progress reports to the Chief Executive and Designated Board Member. The practitioner will always be notified, in writing, of the degree to which their practice is to be restricted, the means by which the restriction will be managed, and the reasons for this action being taken. All restrictions of practice will be registered with the Medical Director, and will be subject to the same review procedure that is associated with the exclusion process (see below).

6.4 The Exclusion Process

Key features of Exclusion from Work are as follows:

- An initial "immediate" exclusion of no more than two weeks if warranted;
- Notification of the NCAS before formal exclusion;

- Formal exclusion (if necessary) for periods up to four weeks;
- Advice on the case management plan from the NCAS;
- Appointment of a Board member to monitor the exclusion and subsequent action;
- Referral to NCAS for formal assessment, if part of case management plan;
- Active review 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 performance assessment.

Where exclusion, rather than restricting practice, is deemed an essential course of action, the Trust 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 exclusion procedures, key officers and the Board have responsibilities for ensuring the process is carried out quickly and fairly, kept under review, and that the total period of exclusion is not unnecessarily prolonged.

6.5 Persons involved

The **Chief Executive** has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. Therefore, before a decision is taken to exclude a practitioner, the reasons for exclusion will be discussed fully with the **Chief Executive, Medical Director, HR Director** or their nominated representatives, the NCAS and other interested parties (such as the police where there are serious criminal allegations, or the Counter Fraud and Security Management Service). In the rare cases where immediate exclusion is required (see below), the Medical Director and HR Director, or their nominated representatives, must discuss the case at the earliest opportunity following exclusion, by means of a case conference.

For immediate exclusions, the authority to exclude a practitioner at consultant level is vested in the Chief Executive, Medical Director, HR Director, or other member of the Executive Team, only. For staff below consultant level, **DCDs** and **CDs** have the authority to exclude. For staff in training grades, the Director of Postgraduate Medical and Dental Education has the authority to exclude.

Where the decision to exclude a practitioner arises from an investigatory process, the **Investigating Officer** will provide factual information to assist the **Case Manager** in reviewing the need for exclusion and in making reports on progress to the Chief Executive or **Designated Board Member**.

The Designated Board Member (see Management Instructions and Guidance, at **Appendix 2**) will ensure that time frames for investigation and/or exclusion are adhered to.

6.6 Immediate Exclusion

In exceptional circumstances, an immediate time-limited exclusion of no more than two weeks may be necessary, for the following reasons:

- to protect the interests of patients, the practitioner or other staff;
- following ☐ a critical incident when serious allegations have been made;
- where there has been a serious breakdown in relationships between a colleague and the rest of the team;
- where the presence of the practitioner is likely to hinder an investigation.

Such an exclusion will allow a more measured and dispassionate consideration to be undertaken, following an incident. This 'breathing space' will be used to carry out a preliminary situation analysis, to contact the NCAS for advice and to convene a case conference. The person making the immediate exclusion (i.e. **Chief Executive, Medical Director, HR Director, Executive Director, DCD, CD or Director of Postgraduate Medical and Dental Education**), must explain to the practitioner:

- in broad terms, why there is a need to make an immediate exclusion (there may be no formal allegation at this stage);
- that they will be informed, at the earliest opportunity, when they will be called back to attend a further meeting: This will be at the earliest opportunity, but in any case, no longer than one working week following immediate exclusion, at which time the practitioner will be notified of the precise nature of the allegation, including specific incidents, dates, persons involved, etc.);
- that immediate exclusion in no way amounts to disciplinary action.

6.7 Formal Exclusion

No practitioner will be excluded from work, other than through a formal procedure. No 'informal' exclusions, of whatever type, will be invoked by the Trust. A formal exclusion may only take place after the Case Manager has first considered, at a case conference, involving the Medical Director, HR Director and Designated Board Member, whether there is a reasonable and proper case to exclude.

The NCAS must always be consulted, by the Case Manager, where the intention is to invoke formal exclusion, following which the appropriate CD or DCD, Medical Director and/or HR Director will be responsible for informing the practitioner of the exclusion. This action will be taken via a formal meeting, at which:

- the practitioner may be accompanied by a companion (see 5.2.13, above);
- the CD/DCD or Medical Director will have an HR colleague present who may be the HR Director, as an independent witness;
- the precise nature of the allegations or areas of concern will be conveyed to the practitioner;
- the practitioner will be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case;
- the practitioner will 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 formal exclusion will be confirmed in writing, as soon as is reasonably practicable. This confirmation will state the effective date and time; duration (up to 4 weeks); the content of the allegations; the terms of the exclusion (e.g. total exclusion from the premises - see **Management Instructions and Guidance, at Appendix 2** - or exclusion from a particular place of work); the need to remain available for work, and that a full investigation (or what other action) will follow. The practitioner will be advised that they may make representations about the exclusion to the Designated Board Member at any time after receipt of the letter confirming the exclusion.

In cases where disciplinary procedures are being followed, and where a return to work is considered inappropriate, exclusion may be extended for four-week renewable periods. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, as soon as the original reasons for exclusion no longer apply.

If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of their control (for example because of a police investigation), the case must be referred to the NCAS, who will advise whether the case is being handled in the most effective way and suggest possible ways forward. However, even during this prolonged period, the principle of four-week 'renewability' will be adhered to.

If, at any time after the practitioner has been excluded from work, 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, inform the Strategic Health Authority, and make arrangements for the practitioner to return to work with any appropriate support, as soon as practicable.

Keeping Exclusions under Review

Informing the Trust Board

The Trust Board will be informed of an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed, and will therefore:

- require a summary report of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed, and that all reasonable efforts are being made to bring the situation to an end as quickly as possible. The Case Manager is responsible for providing such reports to the Board, via the HR Director;
- receive a monthly statistical summary showing all exclusions, with their duration and number of times the exclusion has been reviewed and extended (a copy will also be sent to the Strategic Health Authority). The HR Director is responsible for this activity.

Regular review

The Case Manager will review the exclusion before the end of each exclusion period (which may be up to four weeks each), and report the outcome to the Chief Executive and Trust Board. This report is advisory and it is for the Case Manager to decide on the next steps, as appropriate. The exclusion should be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The Trust must take review action before the end of each four-week period: Otherwise, on expiry of the four-week period, the exclusion will lapse and the practitioner will be entitled to return to work. Following three successive four-week exclusion periods, the NCAS must be called in.

The review activities that will be undertaken at different stages of exclusion are as follows (see below):

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 situation: ▪ The Case Manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time. ▪ Case Manager submits advisory report of outcome to the HR Director and Medical Director. ▪ Each renewal is a formal matter and must be documented as such: The practitioner must be sent written notification on each occasion. The HR Director or Divisional HR Manager is responsible for ensuring these actions are completed.
Third Review	If the practitioner has been excluded for three periods: ▪ The Case Manager submits a situation report to the Chief Executive, 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 Chief Executive must then report to the Strategic Health Authority (SHA) and the Designated Board Member (see Management Instructions and Guidelines, at Appendix 2). ▪ The case must formally be referred to the NCAS, explaining: - why continued exclusion is appropriate; - what steps are being taken to conclude the exclusion at the earliest opportunity. The NCAS will review the case with the SHA and advise the Trust on the handling of the case until it is concluded.

Stage	Activity
5 Months Review N.B: Normally there will be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned, and where the investigation is lengthy. The Trust and the NCAS will actively review such cases at least every 6 months.	If the exclusion has been extended over six months: ▪ The Chief Executive submits a further situation report to the SHA indicating: - the reason for continuing the exclusion; - the anticipated time scale for completing the process; - the actual and anticipated final costs of the exclusion. ▪ The SHA will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any practical advice to be offered to the Trust Board.

6.8 Review

Where a practitioner considers that a decision to exclude or restrict practice has been applied unfairly, or that there are other reasonable alternatives to exclusion, then the practitioner may apply to have their reasons considered and determined at a meeting of the Review Committee (see paragraph 5.2.14). Such a referral may only proceed with the agreement of the Medical Director and LNC Chair.

7.0 Procedures for Dealing with Issues of Capability

Wherever possible, the Trust will aim to resolve issues of Capability (including clinical competence and health) through ongoing assessment and support, which might include counselling and/or re-training. The NCAS has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and will always be consulted by the Case Manager. Any concerns about Capability relating to a doctor or dentist in a recognised training grade will be considered initially as a training issue and dealt with via the Director of Postgraduate Medical Training and college or clinical tutor, with close involvement of the Postgraduate Dean from the outset.

Capability may be affected by ill-health. Procedures for handling concerns about a practitioner's health are detailed in **Section 5** of this policy.

The Trust will ensure that investigations and Capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability, age or indeed on other grounds. Case Managers and Investigators will receive appropriate and effective training in the operation of Capability procedures. Those undertaking investigations or sitting on Capability or appeals panels will have received formal equal opportunities training before undertaking such duties.

Capability Procedure

Further to the decision taken at Stage 5 of 'Procedure When a Concern Arises':

The Pre-hearing Process

When a report of the investigation has been submitted by the Case Investigator, the Case Manager will give the practitioner the opportunity to comment in writing on the factual content of the report. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in particularly complex cases or due to annual leave, the deadline for comments from the practitioner will be extended.

The Case Manager will decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. Notwithstanding that such actions may already have been taken, the Case Manager will consider urgently:

- whether action under **Section 2** of this policy is necessary to exclude the practitioner; or
- temporary restrictions should be placed on the practitioner's clinical duties.

The Case Manager will again consider, with the Medical Director and HR Director, whether the issues of Capability can be resolved through local action (such as re-training, counselling, performance review). If this action is not practicable for any reason, the matter must be referred to the NCAS for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The Case Manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments. The NCAS will assist the Trust to draw up an action plan designed to enable the practitioner to remedy any lack of Capability that has been identified during the assessment. The Trust will facilitate the action plan (which has to be jointly agreed by the Trust and the practitioner before it is actioned).

There may be occasion when a case has been considered by the 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 issue should be considered by a Capability Panel (CaP), in which case a hearing will be necessary. If the practitioner does not agree to the case being referred to the NCAS, in the first instance, again a panel hearing will normally be necessary.

The following procedure will be followed prior to a Capability hearing:

- The Case Manager will notify the practitioner in writing of the decision to arrange a Capability 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 Capability 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 choose.
- Wherever practicable, 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 Trust will consider whether a new date should be set for the hearing.
- Should either party request a postponement to the hearing, the Case Manager will be responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not normally less than 30 working days), to proceed with the hearing in the practitioner's absence: The Trust will always act reasonably in deciding to do so.
- Should the practitioner's ill-health prevent the hearing taking place, the Trust's usual sickness absence procedures will be invoked (in accordance with the Staff Policy Framework). The sickness absence procedures take precedence over the Capability procedures and the Trust will take reasonable steps to give the employee time to recover and attend a hearing. Where the practitioner's illness exceeds 4 weeks, they will be referred to the Occupational Health Service. The Occupational Health Service will advise the Trust on the expected duration of the illness and any consequences it may have for the Capability process.
- 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 submit written submissions and/or have a representative attend in their absence.

- Witnesses who have made written statements at the investigation stage may, but will not necessarily, be required to attend the Capability hearing. Following representations from either side contesting a witness statement that is to be relied upon in the hearing, the Chairman may 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 will 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 required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

1.1 The Hearing Framework

- 1.1.1 The CaP will normally be chaired by an Executive Director of the Trust. In addition to the Chair, the Panel will comprise a total of three people; normally two members of the Trust Board, or a senior members of staff appointed by the Board for the purpose of the hearing. The third member will be a medical or dental practitioner not employed by the Trust. The Panel will also be advised by a senior HR representative, nominated by the HR Director (whose main role will be to ensure that due process is followed, throughout) and by a senior clinician agreed with the LNC from the same speciality as the practitioner concerned, but from another NHS employer. As far as is reasonably possible or practicable, no member of the Panel or adviser to the Panel should have been previously involved in the investigation. Membership of the Panel will be agreed with the LNC.

NB: 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 senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

- 1.1.2 Whilst it is for the Trust to decide on the membership of the Panel, the practitioner may raise an objection to the choice of any Panel member, within 5 working days of notification. The Trust will then

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 Trust will provide the practitioner with the reasons for reaching its decision, in writing, before the hearing takes place.

Representation at Capability Hearings

- 1.1.3 The hearing is not a court of law. Whilst the practitioner will be given every reasonable opportunity to present their case, the hearing will not be conducted in a legalistic or excessively formal manner. The protocol to be followed during the hearing is detailed at paragraph 8.7 of this Section.
- 1.1.4 The practitioner will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. 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.

Decisions

The Panel will have the power to make a range of decisions including the following:

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified time scale, with a written statement of what is required and how it might be achieved (stays on record for 6 months).
- Written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Final written warning that there must be an improvement in clinical performance within a specified time scale, with a statement of what is required and how it might be achieved (stays on record for 1 year).
- Termination of contract.

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. For example, there may be matters around the systems and procedures operated by the Trust that the Panel wishes to comment upon.

A record of oral agreements and written warnings will be retained in the practitioner's personnel file, but will be removed following the specified period.

The decision of the Panel will be communicated to the parties as soon as possible, and normally within 5 working days of the hearing. Because of the potential 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.

The decision will be confirmed in writing to the practitioner. This notification will include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC, or any other external/professional body. The practitioner has the right to appeal against the decision, in accordance with the Appeals Procedure at **Section 4** of this policy.

Protocol to be followed for Capability Hearings

As soon as it has been determined that a Capability Panel (CaP) needs to be formed, the practitioner will be provided with written confirmation of this decision, confirmation of the allegations made against them and details of their rights to be accompanied. As soon as possible, thereafter, and at least 20 working days before the hearing, the practitioner will also be informed of the constitution of the Panel, provided with copies of the Case Manager's report and any associated investigation documentation and any documentation and/or evidence that will be made available to the Panel, including witness statements. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will 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 (normally not in excess of 30 days) while this matter is resolved. The trust will provide the practitioner with the reasons for reaching its decision in writing before the hearing takes place.

The Panel's appointed HR representative will act as the Panel Co-ordinator, who is responsible for the administrative aspects relating to the hearing. The Panel Co-ordinator will write to the practitioner to confirm the date and venue set for the hearing, and to request that any written evidence the practitioner wishes to present at the hearing, including witness statements, are submitted at least three working days before that date. The practitioner may invite witnesses to attend the hearing, if they so wish. The Panel Co-ordinator will confirm that everyone involved with the hearing is available to attend, and inform all parties of any necessary changes to the administrative arrangements.

Once the Panel, the practitioner and their representative are assembled, the Chair of the Panel is responsible for managing the hearing, and ensuring the following protocol is followed:

- Chair introduces those present, summarises why the hearing has been convened, and explains how the hearing will be conducted.

- Chair explains that the Panel Co-ordinator will make a written record of the proceedings.
- Chair calls the Case Manager or the Trust's representative to present the case against the practitioner. Case Manager will provide documentary evidence and call witnesses, as appropriate.
- Practitioner and their representative are given the opportunity to ask any questions of the Case Manager and witnesses.
- Panel members are invited to ask questions of the Case Manager and witnesses.
- Practitioner and/or their representative are invited to present their case, and to provide any documentary evidence and call witnesses, as appropriate.
- Case Manager, or the Trust's representative, is given the opportunity to ask questions of the practitioner, their representative, and witnesses.
- Panel members are invited to ask questions of the practitioner, their representative and witnesses.
- Chair may ask questions of either party, and ask for points of clarification.
- Case Manager, or the Trust's representative, is asked to sum up.
- Practitioner, or their representative, is asked to sum up.
- Both parties are asked to leave the hearing, whilst the Panel members confer in private, but to be available to return should the Panel need clarify any points of uncertainty.
- Panel makes its decision and both parties are recalled to be informed, by the Chair, of that decision.
- Where the Panel has determined that there is a proven Capability issue, the practitioner is informed of the disciplinary/administrative action to be taken against them. The practitioner is informed of their right to appeal against the Panel's decision.

Witnesses will be admitted only to give their evidence and answer any questions, and will then retire. The procedure for dealing with any witnesses attending the hearing will be the same and reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;

- the side calling the witness may question the witness;
- the other side may then question the witness;
- the Panel may question the witness;
- the side that called the witness may seek to clarify any points that have arisen during questioning but may not at this point raise new evidence.

Following the hearing, and within three working days, the Panel Coordinator will ensure the practitioner receives written confirmation of the outcome, and of any disciplinary/ administrative action to be taken against them. The practitioner will also be reminded of the Appeals Procedure at **Section 4**, below.

8.0 Appeals Procedure

8.1 Purpose

The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a Panel 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, in arriving at their decision, the Panel acted fairly and reasonably, based upon:

- 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.

The Panel may also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The Panel, however, will not re-hear the entire case.

A dismissed practitioner will, in all cases, be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

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 Capability 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 will have the power to instruct a new Capability hearing.

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

8.2 The Appeal Panel

The appeal panel will consist of three members, who will 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. Membership will be as follows:

- an independent member (trained in legal aspects of appeals) from an approved pool (as agreed and established by the BMA, BDA and NHS Employers - see Appendix 3), designated Chairman;
- the Trust Chairman (or other Trust Non-Executive Director), who will have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate), who is not employed by the Trust, but agreed by the LNC.

All members will be suitably experienced or trained to be able to participate in an appeal hearing.

The Panel will 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 NHS employer;
- a Senior HR specialist.

It is important the Panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable

to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original hearing. Wherever practicable, the following timetable will apply:

- appeal by written statement to be submitted to the designated appeal point (the HR Director, or their nominated representative) 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.

In all cases, the timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager is responsible for ensuring that extensions are absolutely necessary, and kept to a minimum.

8.3 Powers of the Appeal Panel

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. 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 will 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.

If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it will 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 Conduct/Capability hearing panel.

8.4 Conduct of Appeal Hearing

All parties will be in possession of all documents, including witness statements, from the previous hearing, together with any new evidence.

The appellant will be informed of their right, to be accompanied in the hearing, by a companion. In addition to statutory rights under the Employment Relations Act 1999, the companion may be another employee of the Trust; an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation; or a friend, partner or spouse. Such a representative may be legally qualified but they will not, however, be representing the appellant 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.

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 will briefly sum up. At this stage, no new information may be introduced, however the appellant (or their companion) may make a statement in mitigation.

The Panel, after receiving the views of both parties, will consider and make its decision in private.

8.5 Decision

The decision of the appeal panel will be made in writing to the appellant and copied to the 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 will 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 must be sought in writing from the Chairman of the appeal panel.

8.6 Action following Hearing

Records will be kept, including a report detailing the Capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records will remain confidential and retained in accordance with the Data Protection Act 1998. These records will 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 Employment Tribunal.

9.0 Procedures for Handling Concerns relating to a Practitioner's Health

9.1 Introduction

A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress. The underlying principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained, and kept in employment, rather than be lost from the NHS.

5.4 Retaining the Services of Individuals with Health Problems

Wherever possible, the Trust will attempt to continue to employ the practitioner, provided this does not place patients or colleagues at risk². This may involve one or more of the following activities:

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to maintain contact and prevent them from feeling isolated);
- removing the practitioner from certain duties;
- reassignment to a different area of work;
- arranging re-training or adjustments to the practitioner's working environment, with appropriate advice from the NCAS and/or deanery, under reasonable adjustment provision in the Disability Discrimination Act 1995.

At all times, the practitioner will be supported by the Trust and the Occupational Health Service (OHS), who will ensure that the practitioner is offered every available resource to be able to return to practise, where appropriate. The Trust will consider what reasonable adjustments might be made to their workplace conditions, or other arrangements. Examples of reasonable adjustment include:

- making adjustments to the premises;
- re-allocation of some duties to colleagues;
- transfer of the practitioner to an existing vacancy;
- altering the practitioner's working hours, or pattern of work;
- assignment to a different workplace;
- allowing absence for rehabilitation, assessment or treatment;
- provision of additional training or re-training;
- acquiring/modifying equipment;

² *Maintaining High Professional Standards in the Modern HPSS*

- modifying procedures for testing or assessment;
- establishing mentoring arrangements.

In some cases, retirement due to ill-health may be necessary. Ill-health retirement will be approached in a reasonable and considerate manner. However, it is important that the issues relating to conduct or Capability that have arisen are resolved, using the agreed procedures, where appropriate.

9.2 Handling Health Issues

Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine the precise nature of that problem.

In such cases, the Case Manager will immediately refer the practitioner to a consultant occupational health physician within the Trust's OHS. NCAS will also be approached to offer advice on any situation and at any point where the Trust is concerned about a practitioner's health. Even apparently simple or early concerns will be referred, as these are easier to deal with before they escalate.

The Occupational Health physician will agree a course of action with the practitioner and send their recommendations to the Medical Director.

A meeting will then be convened with the HR Director, or their nominated representative, the Medical Director, or their nominated representative, or Case Manager, the practitioner and case worker from the OHS. The purpose of this meeting will be to agree a timetable of action and rehabilitation (where appropriate).

The practitioner may wish to bring a support companion to these meetings, who might be a family member, a colleague or a trade union or defence association representative. Confidentiality will be maintained by all parties, at all times.

If a practitioner's ill-health makes them a danger to patients and they do not recognise that danger, or are not prepared to co-operate with measures to protect patients, then exclusion from work will be considered and the professional regulatory body informed, irrespective of whether or not the practitioner has retired on the grounds of ill-health.

In those cases where there is impairment of performance solely due to ill-health, disciplinary procedures will only be considered in the most exceptional of circumstances, for example if the practitioner refuses to co-operate with the Trust to resolve the underlying situation by repeatedly refusing a referral to the OHS or

the NCAS. In these circumstances, the procedures for dealing with issues of Capability (see Section 3.0) will be followed.

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There will be circumstances where a practitioner who is subject to disciplinary proceedings submits a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the practitioner 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.

Toal, Vivienne

From: Vivienne Toal <[REDACTED]>
Sent: 14 August 2010 10:36
To: Siobhan Hynds
Subject: MHPS HR Version VT August 2010
Attachments: MHPS HR Version VT August 2010.docx

Siobhan

Please see attached MHPS procedure.

When you are talking to Kieran can you ensure he is happy with role of Oversight Group in that they are endorsing the decision of the Clinical Manager as to action to be taken. In light of NCAS formal advice I think this is safe enough and they can have a sufficient challenge function.

Also will you check with him about copying it to LNC - just in case it gets off on wrong footing because they haven't been advised of the document and the roles that individuals will play.

There is definitely room for more cross referencing of the procedures to the MHPS framework and best practice guidance - will you have a look to see if more references can be entered?

Finally - will you read through to make sure I have not stated anything that is not correct i.e. goes against MHPS framework.

Sorry to dump this on you - but hopefully this gets the bulk of the text done.

Before sharing with Kieran - will you run it past Debbie, and then send to Kieran with copy to Anne and Debbie. Let Kieran send it on to Mairead and Debbie once he is happy with it.

Thanks

Vivienne



Southern Health
and Social Care Trust

Procedure for Handling Concerns and Doctors' and Dentists' Performance

DRAFT

1.0 Introduction

1.1 Maintaining High Professional Standards in the Modern HPSS
A framework for the handling of concerns about doctors and dentists in the HPSS (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

1.2 The MHPS framework is in six sections and covers:

- I. Action when a concern first arises
- II. Restriction of practice and exclusion from work
- III. Conduct hearings and disciplinary procedures
- IV. Procedures for dealing with issues of clinical performance
- V. Handling concerns about a practitioner's health
- VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This procedure, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.

- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

- 1.5** This procedure also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of poor medical performance.
- 1.6** This procedure applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.
- 1.7** This procedure should be read in conjunction with the following documents:

Annex A

“Maintaining High Professional Standards in the Modern NHS”
DHSSPS, 2005

Annex B

“How to conduct a local performance investigation” NCAS, 2010

Annex C

SHSCT Disciplinary Procedure

Annex D

SHSCT Clinical Manager’s MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1 NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also indicates that anonymous complaints and concerns based on ‘soft’ information should be put through the same screening process as other concerns.
- 2.2 Concerns should be raised with the practitioner’s Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director (in error) then the Medical Director cannot be involved in the OG nor can they sit on any formal panel hearing.
Up to MD to stop someone from making complaint known to him, in the same way as someone making a complaint to one of our Assistant Directors – they don’t get involved in the detail and refer the person to the relevant Manager where possible?? **Siobhan – will you speak to KD on this point – Debbie had it in her version.**
- 2.3 MHPS (2005) states that **all** concerns must be registered with the Chief Executive and therefore the Clinical Manager will be responsible for informing the Chief Executive that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human

Resources & Organisational Development and the relevant Operational Director.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for assessing what action should be taken in response to the concerns raised. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach.

2.8 The Clinical Manager and the HR Case Manager will present their assessment to the OG for endorsement of their decision on the action to be taken to deal with the concerns raised. The role of the Oversight Group is therefore to quality assure the decision of the Clinical Manager and HR Case Manager and promote fairness, transparency and consistency of approach to the process of handling concerns. Reference Paragraph 15 - MHPS 2005

- 2.8 The Chief Executive will be informed of the action to be taken by the OG.
- 2.9 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the OG will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 6 of this document.

Appendix 1

An informal process. This can lead to resolution or move to:

Appendix 2

A formal process. This can also lead to resolution or to:

Appendix 3

A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4

An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5

Exclusion can be used at any stage of the process.

Appendix 6

Role definitions

- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.
- 3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).
- 3.4 The Southern Trust (who? - MD) will also present all formal investigation processes to the SMT Governance Committee retrospectively after any panel hearing, to promote learning and for peer review.

Appendix 6**Role definitions and responsibilities****Screening Process / Informal Process****Clinical Manager**

The person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a Senior HR Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

Usually the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group endorses the decision of the Clinical Manager and Senior HR represent as to action to be taken in response to concerns raised following initial assessment.

Formal Process**Chief Executive**

The Chief Executive in conjunction with the Oversight Group, appoints a Case Manager and Case Investigator. Chief Executive will inform the Chairman of formal investigation and requests that a Non-Executive Director is appointed as “designated Board Member”.

Case Manager

Usually the Associated Medical Director. S/he coordinates the investigation, ensure adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

Usually the Clinical Director. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and present the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in the instance.

Non Executive Board Member

Assures that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to trust Board.

Toal, Vivienne

From: Donaghy, Kieran <[REDACTED]>
Sent: 16 September 2010 13:05
To: McAlinden, Mairead; Rice, Francis; Dornan, Brian; Rankin, Gillian; Loughran, Patrick; McVeigh, Angela; McNally, Stephen; Clarke, Paula; Walker, Helen
Cc: Burns, Deborah; Hynds, Siobhan; Toal, Vivienne; Clegg, Malcolm; Brennan, Anne
Subject: Trust Guidelines for Handling Concerns about Doctors and Dentists Performance
Attachments: Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 15 September 2010.doc

As discussed at SMT yesterday, please find enclosed copy of the final and agreed version of the above guidelines. This will now form the basis of our training on 24th September 2010.

Please circulate as appropriate.

Regards,

Kieran



Southern Health
and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

16 September 2010

1.0 Introduction

1.1 Maintaining High Professional Standards in the Modern HPSS *A framework for the handling of concerns about doctors and dentists in the HPSS*

(hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 The MHPS framework is in six sections and covers:

- I. Action when a concern first arises
- II. Restriction of practice and exclusion from work
- III. Conduct hearings and disciplinary procedures
- IV. Procedures for dealing with issues of clinical performance
- V. Handling concerns about a practitioner's health
- VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.
- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

- 1.5** This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.
- 1.6** This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.
- 1.7** This guidance should be read in conjunction with the following documents:

Annex A

“Maintaining High Professional Standards in the Modern NHS”
DHSSPS, 2005

Annex B

“How to conduct a local performance investigation” NCAS, 2010

Annex C

SHSCT Disciplinary Procedure

Annex D

SHSCT Clinical Manager’s MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1** NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

- 2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.
- 2.3 Concerns which may require management under the MHPS framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.
- 2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

- 2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expeditiously as possible and the Oversight Group will monitor progress.
- 2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.
- 2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.
- 2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1

An informal process. This can lead to resolution or move to:

Appendix 2

A formal process. This can also lead to resolution or to:

Appendix 3

A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4

An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5

Exclusion can be used at any stage of the process.

Appendix 6

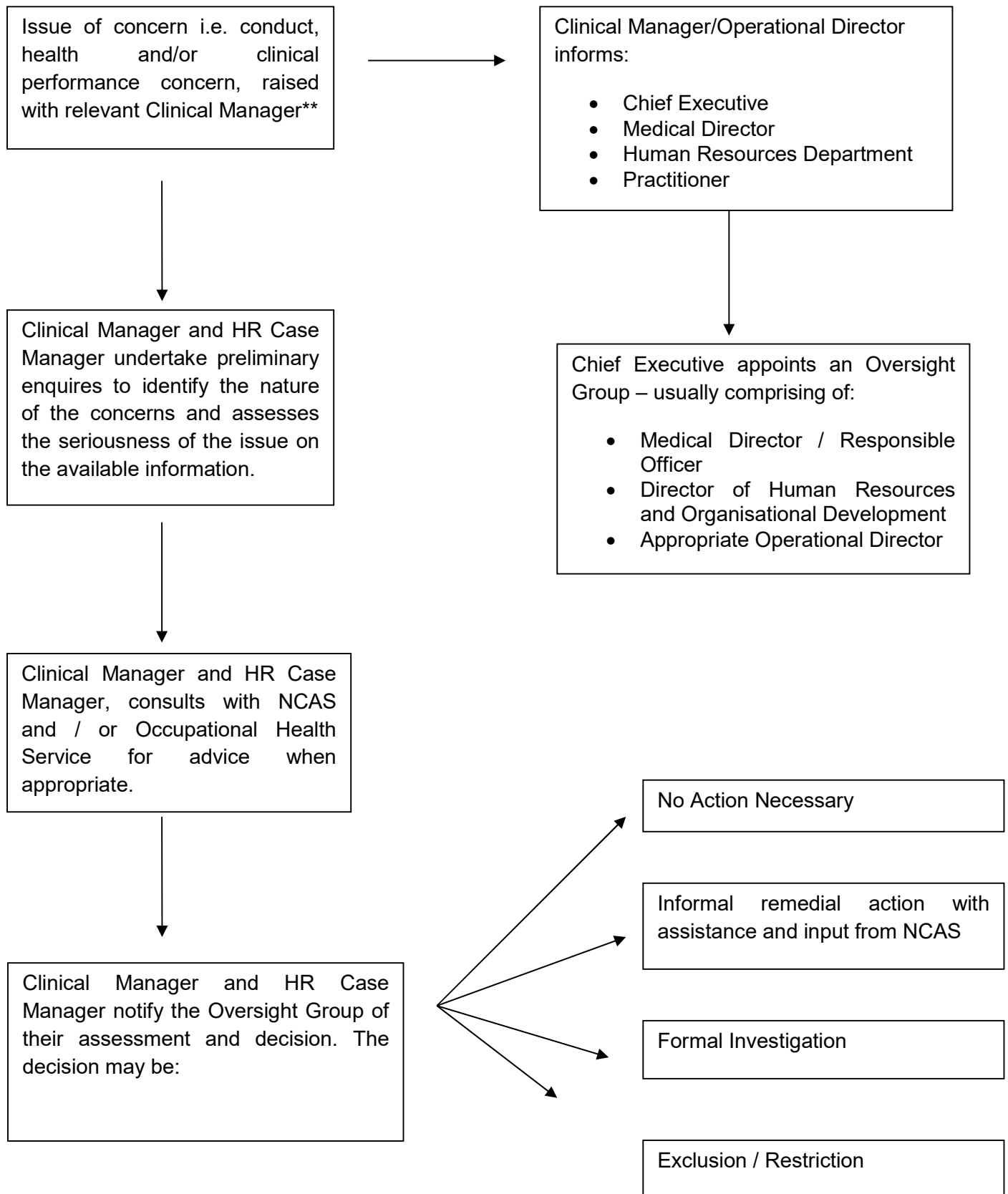
Role definitions

- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

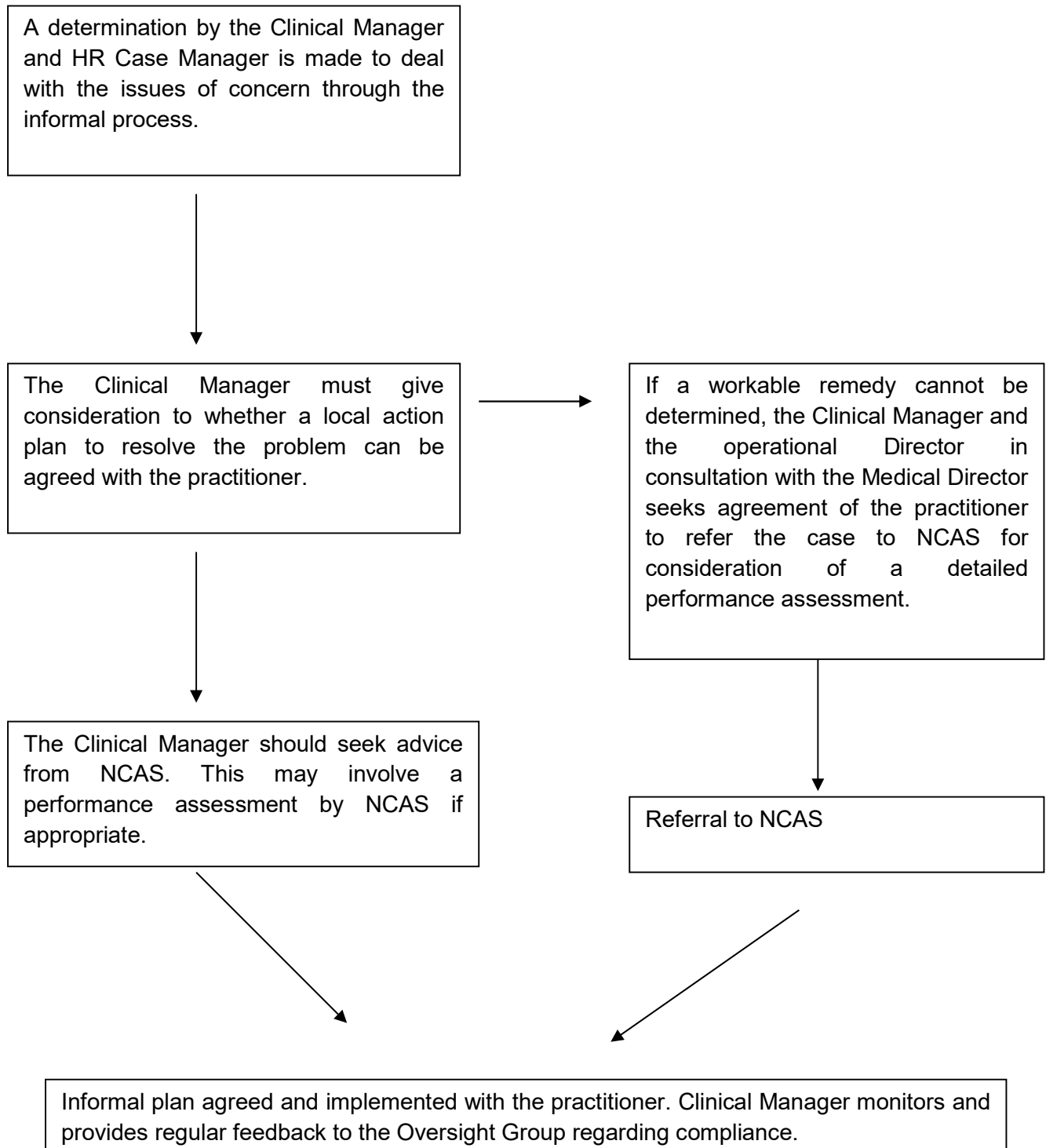
- 3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).
- 3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.
- 3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, 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 not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

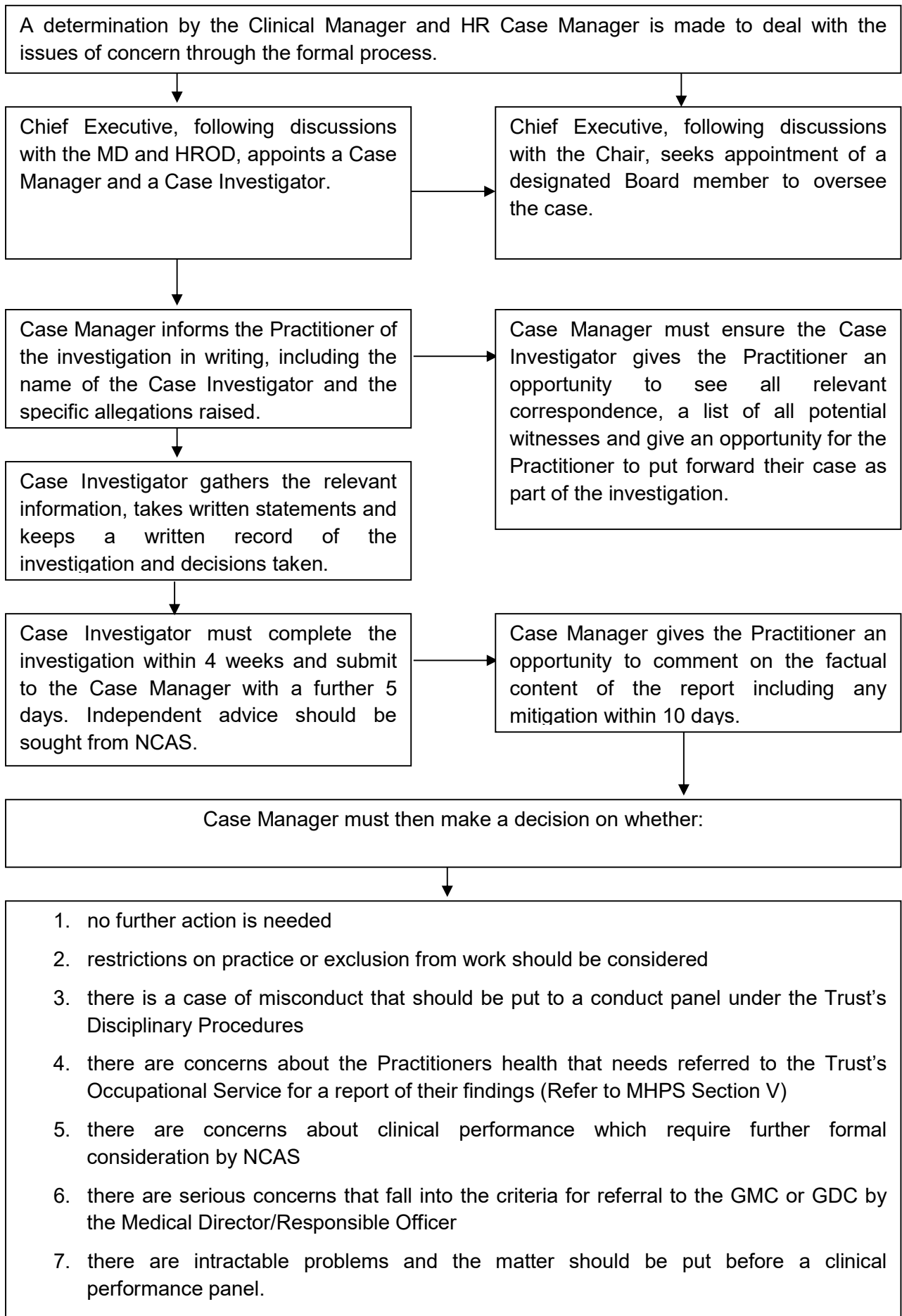
Step 1 Screening Process

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

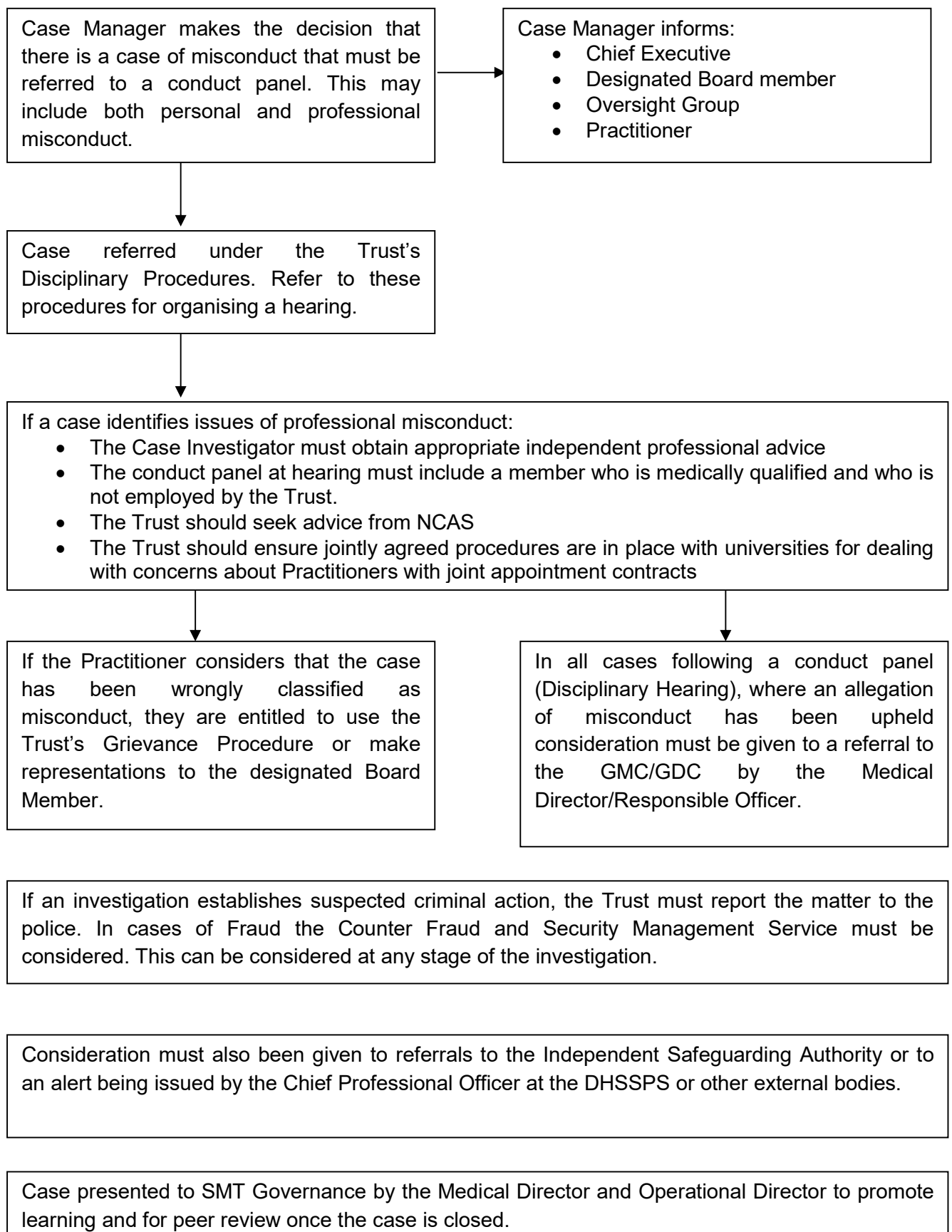
Appendix 1

Step 2 Informal Process

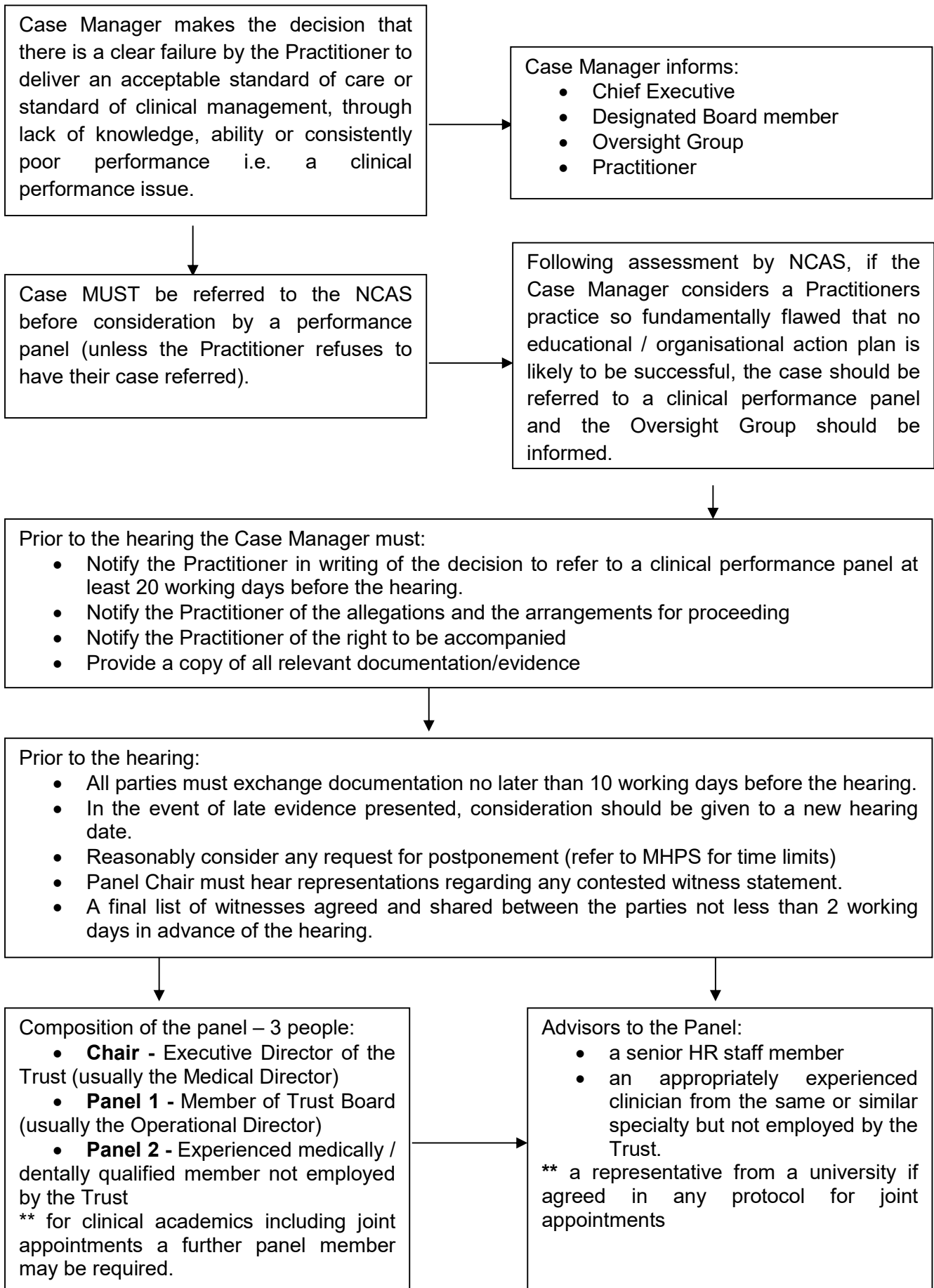
Appendix 2

Formal Process

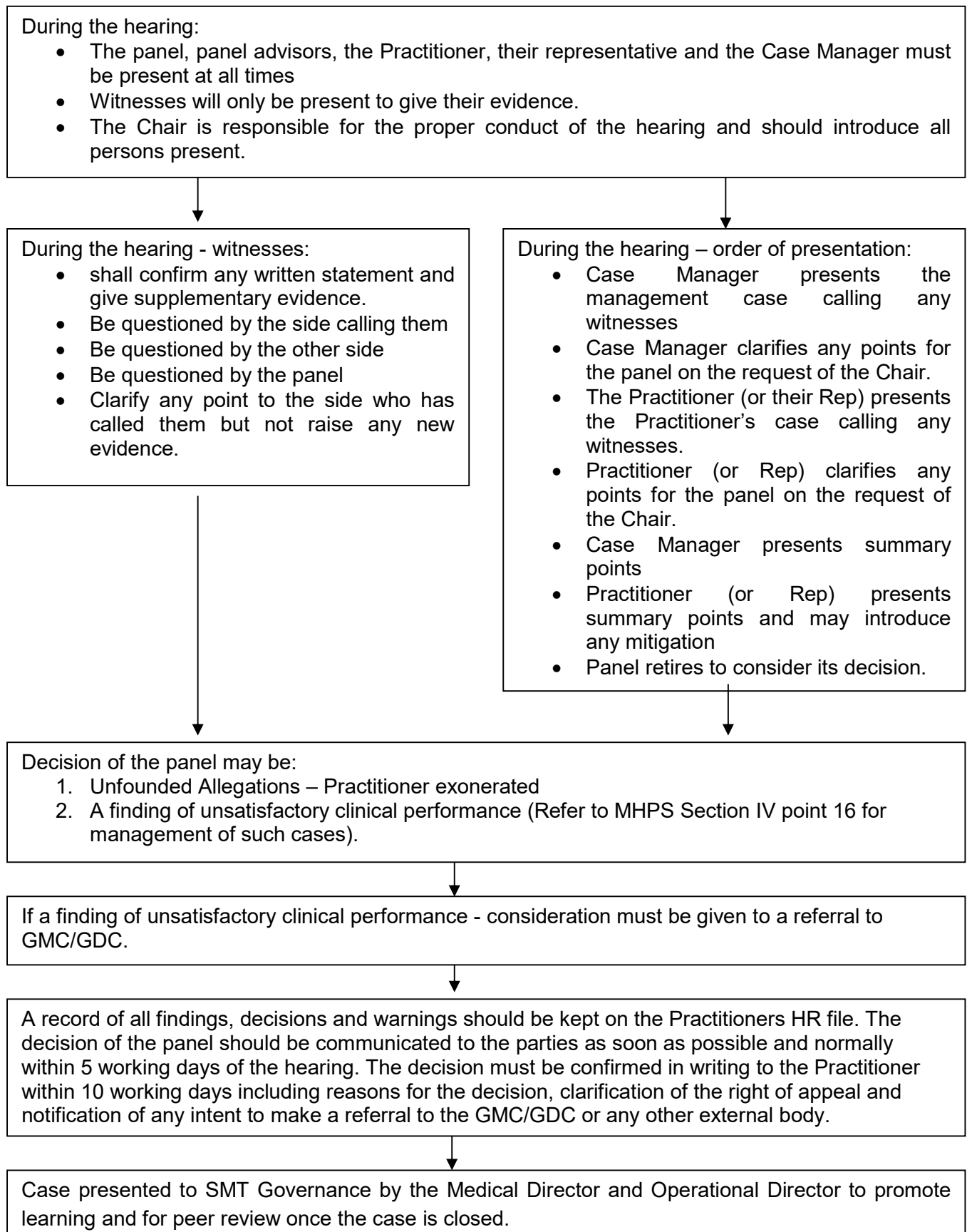
Appendix 3

Conduct Hearings / Disciplinary Procedures

Appendix 3a

Clinical Performance Hearings

Appendix 3a

Clinical Performance Hearings

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

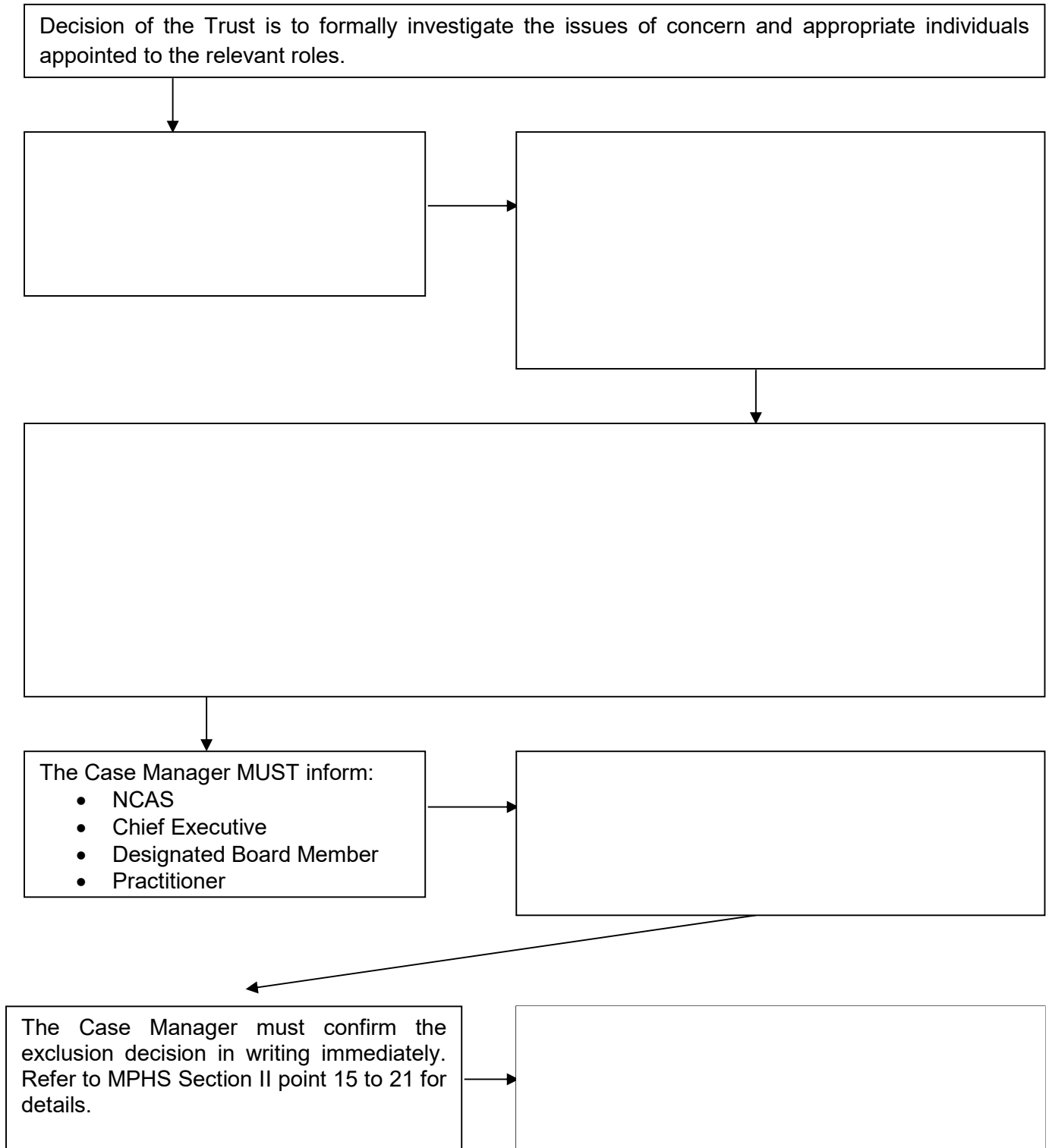
The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Restriction of Practice / Exclusion from Work**Formal Exclusion**

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.



Quality Care - for you, with you

Notes of SMT Meeting held on
Wednesday 8 September 2010
@ 2.00pm in the Boardroom, Trust Headquarters

Present: Mairead McAlinden
Dr Rankin
Dr Loughran
Angela McVeigh
Paula Clarke
Kieran Donaghy
Brian Dornan
Helen O'Neill (for Stephen McNally)
Francis Rice
Edel Bennett (for Ruth Rogers)
Elaine Wright (Notes)

Apologies: Stephen McNally, R Rogers

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Mr McNally and Mrs Rogers.	
2	NOTES OF MEETING HELD ON 1 SEPTEMBER 2010 The notes of the meeting held on 1 September 2010 were approved.	
3	MATTERS ARISING 3.1 Junior Doctors Allocation: Analysis of Service/Finance Risks Dr Rankin distributed a paper regarding Obs & Gynae and discussed the detail with members. Members considered the suggested options and approved some elements.	

	Following discussion, Dr Rankin agreed to update the paper for the remaining proposals. Surgical – Dr Rankin distributed and spoke to the Surgical paper. It was agreed that Dr Rankin and Dr Loughran would address separately, and Dr Rankin would bring this paper back to the table for next SMT. 3.2 Procedures for Handling Concerns about Doctors & Dentists Performance – draft paper A draft report on the procedures for Handling Concerns about Doctors and Dentists Performance was distributed. Members were asked for comments before the next meeting, when formal sign off will take place. Mr K Donaghy agreed to issue an up to date version prior to the next meeting, incorporating Dr Loughran’s comments. NCAS Training – diary date of 24 September was noted for Directors attendance. 3.3 Professional Development & Training – Medical Staff An updated paper was distributed. Following consideration, members agreed to a combination of option 1 and 2 and with the changes noted, Dr Loughran agreed to amend and reissue via his office. 3.4 SUMDE Funding This item was deferred to the next meeting.	<i>Dr Rankin</i> <i>Dr Rankin/ Dr Loughran</i> <i>K Donaghy SMT: 15 Sept 2010</i> <i>A//</i> <i>Dr Loughran</i> <i>SMT: 15 Sept 2010</i>
4	PERFORMANCE UPDATE 4.1 Performance Report Mrs Clarke referred to the Trust Performance and members noted areas of emerging risks and measures to address same. Mrs Clarke advised that the quarterly report had previously been circulated. Mrs Clarke gave an update on the Directors Performance meeting also.	

5	FINANCIAL PLAN 2010/11 5.1 Scrutiny Process – Approvals for Recruitment Members addressed the Scrutiny Process. Approvals were agreed. It was agreed that turnover information would be provided to inform further discussions. 5.2 Hospital at Night Dr Rankin referred to Hospital at Night and provided a position update. Further updates will be given at the next meeting. 5.3 NIAO – 2009/10 Report to those Charged with Governance Members noted the above NIAO Report. Ms O'Neill advised that action required was underway to address highlighted areas. Directors were asked to note recommendations and action required. 5.4 Financial Stability Programme – Assessment Review Report The Acting Chief Executive provided an update following the Regional Board Financial Stability Programme Meeting. The Chief Executive provided an overview of the action plan and referred to a copy of the presentation given at the meeting. 5.5 Charges for A&E Attendances Members referred to the paper regarding Charges for A&E Attendances. Dr Rankin provided an update on the Trust position and actions taken to date. Members agreed to implement from 1 October 2010 and to adopt the higher rate outlined.	<i>Mr Donaghy</i> <i>SMT: 15 Sept 2010</i> <i>All</i> <i>Dr Rankin</i>
6	GOVERNANCE ISSUES 6.1 Preceptorship Briefing Paper Dr Glynis Henry attended the meeting to discuss the briefing paper regarding Preceptorship. Dr Henry advised that this should be applied as best practice to new registrants and those returning to practice.	

	Discussion took place regarding the practicalities of the programme and the need to include guidance on how to support appointments outside the recruitment cycle. Members agreed, that with the caveats mentioned, the programme should proceed, and approved same. 6.2 Registered Nurses employed on Bank only contract – Acute & OPPC Directorates Dr Henry referred to the above paper which affects Acute and OPPC Directorates primarily. Dr Henry outlined the content of the paper, which provides a basic induction for staff to facilitate them to work in a ward setting. Issues pertaining to specific areas such as MEWS were raised. Mr K Donaghy said that this work was welcomed and suggested its application across other disciplines. Dr Henry advised that work was ongoing in relation to bank staff and associated training. Members approved the principle of the paper. 6.3 SAI Personal information redacted by the Dr Rankin provided a verbal update to members regarding SAI Personal information redacted by the. She assured members that measures are in place to address issues raised by this SAI. 6.4 Call for Evidence & Post Implementation Review on the Current Data Protection Legislative Framework Members referred to the above paper and Mrs Clarke outlined the main content of same. She advised that a composite response from all NI Departments will be issued and this provides the Southern Trust inclusion to that. Members were asked to submit any final comments to Mrs Clarke by Friday 10 September and Mrs Clarke will then submit the Trust response.	<i>Mr Rice</i> <i>All/P Clarke</i>

	6.5 RQIA Review of GP Out of Hours Services Mrs McVeigh referred to the RQIA Review of GP Out of Hours Services and the recommendations highlighted within. Members referred to the Trust's action plan to address the recommendations and Mrs McVeigh assured members that work was progressing to address these. It was agreed to table at the next SMT Governance Meeting and then to Trust Board in November. 6.6 Card Before you Leave Scheme Members referred to the recent media coverage surrounding the 'Card before you Leave Scheme' and the Trust's paper addressing issues raised. Members were assured that the Trust was handling the Scheme and has a process in place to address any issues that may arise. Mr Rice agreed to consider evaluation of impact/effectiveness. 6.7 Dress Code Policy Members noted the proposed communication in respect of the Dress Code Policy and the need to issue to all staff as soon as possible to reinforce the need to adhere to Trust Policy in this regard. Members approved for circulation. 6.8 1st Quarter Patient Support Services Report, 1.04.2010-30.06.2010 Dr Rankin referred members to the Patient Support Services Report for the period 1 April 2010 – 30 June 2010. Members agreed this was a useful report which will now be tabled at the forthcoming Patient/Client Experience Committee. 6.9 Report on Out of Hours Data Breach Mrs McVeigh provided an updated SAI/RCA report. The Chief Executive advised that a Trust Wide circulation had been issued reminding staff of their responsibilities with regard to the handling of such data. The GP Out of Hours Data Breach SAI/RCA will be tabled at the next Governance Committee.	<i>SMT Governance – 29 Sept 2010</i> <i>Trust Board – 30 Nov 2010</i> <i>Mr Rice</i> <i>Paula McKeown</i> <i>Dr Rankin – next Patient/Client Exp Committee</i> <i>Governance Committee – 7 December 2010</i>

7	INFECTION CONTROL UPDATE 7.1 Weekly Hand Hygiene and Commode Audit Overview The Audit exemption reports with regard to hand hygiene and commodes were noted. 7.2 Environmental Cleanliness Weekly Exception Reports Members noted the environmental cleanliness exception reports. Directors to action as necessary.	
8	CSR/CHANGING FOR THE BETTER – 5 YEAR STRATEGIC PLAN 8.1 Changing for Children – draft consultation report Members noted the Changing for Children consultation document which will be tabled at Trust Board on 30 September 2010. Members were asked for views/comments before next weeks SMT meeting, where the report will be signed off. Members discussed the key issues of the report and the need to ensure a safer service whilst striving to meet targets. A presentation of the outcomes of the consultation will be made at the Trust Board Meeting. 8.2 Corporate Plan Members considered the format for the Corporate Plan which will be presented to Trust Board on 30 September 2010. Discussion took place with regard to how the Trust move and progress its objectives and making the connection between objectives and the 5 year plan.	<i>SMT – 15 September 2010</i> <i>Trust Board 30 September 2010</i> <i>Trust Board 30 September 2010</i>
9	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 9.1 Summary of Internal Capital Business Cases This paper was deferred to the next SMT meeting.	<i>SMT – 15 Sept 2010</i>

	9.2 Minor Works Members referred to the paper regarding Minor Works, and were asked to prioritise their lists for SMT on 22 September 2010.	<i>SMT – 22 Sept 2010</i>
10	WORKFORCE ISSUES 10.1 Trust Excellence Awards Members noted that the material regarding the Trust Excellence Awards had been circulated throughout the Trust. 10.2 Hope Exchange Programme – NHS Institute Following consideration of the Hope Exchange Programme, it was agreed that the Trust would not avail of the opportunity to participate this year. 10.3 Travelwise Mr Rice referred members to the Travelwise Scheme which involves joint working arrangements between the Trust and DRD Transport Policy Division, who will work with the Trust to develop a travel plan. Members noted that the Trust would not incur any financial charges with this scheme. Members approved to proceed.	<i>Mr Rice</i>
11	CARBON REDUCTION COMMITMENT (CRC) ENERGY EFFICIENCY SCHEME SUMMARY REPORT Mrs Clarke referred to the CRC Energy Efficiency Scheme Summary Report. She advised that the report provides information and raises awareness of action that can be taken within Directors to reduce Carbon Energy. Mrs Clarke advised that systems are being put in place to monitor energy usage within facilities. Members noted the report and its content.	
13	WEEKLY COMMUNICATIONS TELECONFERENCE Members considered the content of the weekly communications teleconference.	

14	ANY OTHER BUSINESS 14.1 Mono Hips Dr Rankin advised members regarding the 'alert' received for mono hips and the possible impact upon the Trust. Discussion took place with regard to the approach the Trust should take regarding this matter. Dr Rankin agreed to advise further at the next meeting. 14.2 CAWT This item was deferred to the next meeting. 14.3 Community Development Training Programme Mrs McVeigh advised that information was in the process of being circulated and an updated action plan being prepared. 14.4 Governance Review Members were advised that following the Governance Committee Meeting, proposals for new structures will be prepared and released as part of the consultation process. This process will commence at the end of October/beginning November.	<i>Dr Rankin SMT 15 Sept 2010</i> <i>SMT – 15 Sept 2010</i>
15	DATE OF NEXT MEETING The next SMT meeting will be held on Wednesday 8 September 2010 commencing at 2.00pm.	



Southern Health
and Social Care Trust

Quality Care - for you, with you

Notes of SMT Meeting held on
Wednesday 15 September 2010
@ 2.00pm in the Boardroom, Trust Headquarters

Present: Mairead McAlinden
Dr Rankin
Dr Loughran
Angela McVeigh
Paula Clarke
Kieran Donaghy
Brian Dornan
Stephen McNally
Francis Rice
Paula McKeown (for Ruth Rogers)
Elaine Wright (Notes)

Apologies: R Rogers

ITEM	NOTE	ACTION
1	APOLOGIES Apologies were received from Mrs Rogers.	
2	NOTES OF MEETING HELD ON 8 SEPTEMBER 2010 The notes of the meeting held on 8 September 2010 were approved.	
3	MATTERS ARISING 3.1 Junior Doctors Allocation: Analysis of Service/Finance Risks - <i>Surgical</i> Copies of a revised paper were issued to members. Following consideration, members agreed to approve, proposing Option 4 which enables a reduced level of additionality and covers educational concerns which may arise. Members approved.	<i>Approved</i>

	3.2 Procedures for Handling Concerns about Doctors & Dentists Performance – draft paper Members considered the revised procedures and following clarification of some issues and with the caveats agreed, members approved and adopted the process outlined. Dr Loughran advised of the various groups who will receive the procedures and Elaine Wright to amend and forward to Dr Loughran and K Donaghy immediately following SMT for circulation as agreed. 3.3 Professional Development & Training – Medical Staff Members noted the changes following discussions at the last SMT meeting, which allow for the management of the speciality budget and flexibility within. Members endorsed the documents. 3.4 Hospital at Night Dr Loughran advised that the Southern Trust has now received £146K for the Hospital at Night Project. Members noted that costs were now covered and acknowledged this good news. 3.5 CAWT Issues/Update Mrs McVeigh referred members to the paper entitled: 'CAWT Promoting Independence & Providing Social Support for Older People Project'. Members discussed the content of the paper and following consideration of the options outlined, agreed to option 2 in principle – <i>to ensure the needs of older people are assessed using agreed criteria to ensure need is prioritised and the services targeted at those most in need and within available resource.</i> 3.6 Mono Hips Dr Rankin advised that further correspondence had been received and that she had raised the issue regionally. Dr Rankin informed members that lists were being validated and a plan of action will be drawn up by the end of October.	<i>E Wright to amend and issue – Dr Loughran/K Donaghy</i> <i>Approved</i> <i>Agreed – A McVeigh</i> <i>Dr Rankin – end October 2010</i>

	3.7 Shared Services Mr McNally advised that he would table a local response at the next SMT Meeting. 3.8 Structure for Trust Sub Deanery This item was deferred to the next SMT Meeting. Dr Loughran agreed to respond to the most recent correspondence regarding the Trusts response to this.	<i>S McNally SMT 22 Sept 2010</i> <i>Dr Loughran to respond and SMT 22 Sept 2010</i>
4	PERFORMANCE UPDATE 4.1 Performance Report Mrs Clarke asked Directors to give thoughts to inclusions within the Performance Report and agreed to table a paper at the next SMT Meeting, for approval for submitting to Trust Board on 30 September 2010. 4.2 Variation to Corporate Performance Management Report – Proposal for Discussion Mrs Clarke outlined suggestions for new format of this report which were agreed by SMT. 4.3 Corporate Performance Dashboard, August 2010 Members referred to the Corporate Performance Dashboard for August 2010 which is used as an exception reporting tool. Mrs Clarke asked members to provide her with comments as appropriate. 4.4 SBA Performance Report April-July 2010 Mrs Clarke referred to the SBA Performance Report for the period April-July 2010. Mrs Clarke advised that this report will come to SMT every second month and will be a rolling programme of work within the Trust. Members agreed their content to the process. 4.4 Elective Care PfA Waiting Time Targets, Letter from John Compton 14 September 2010 The Chief Executive referred to correspondence from Mr John Compton regarding Elective Care PfA Waiting Time Targets and the request to have the Trusts detailed plans	<i>P Clarke - SMT 22 Sept 2010</i> <i>P Clarke All</i>

	by the end of the week. Members agreed that the Trust were progressing, although it would not be feasible to have finalised by week end.	
5	FINANCIAL PLAN 2010/11 5.1 Scrutiny Process – Approvals for Recruitment Members addressed the Scrutiny Process. Approvals were agreed. Mr K Donaghy requested that the report regarding 'turnover' is deferred until the next SMT Meeting. 5.2 Gifts and Hospitality 2010/11 Mr McNally tabled a paper regarding the outcome of the Internal Audits review of the Trusts Gifts & Hospitality for 2010/11. Members noted that the issue still remains regarding 'sponsorship' and Mr K Donaghy advised that a one page guidance for staff was being produced. 5.3 SUMDE – Infrastructure Upgrade Funding Dr Loughran advised that he was currently working on this alongside Mrs Clarke and this item was deferred to the SMT Meeting on 22 September 2010 when a report would be available. 5.4 SUMDE Funding – draft briefing paper Members noted the SUMDE Funding draft briefing paper and were asked to consider its contents. This will be tabled for further discussion at SMT on 29 September 2010. 5.5 Proposal to remove payment of telephone line rental to Trust Staff Members considered and agreed the paper proposing to remove payment of telephone line rental to Trust staff and Mr K Donaghy advised that he would bring this proposal through staff side. Mr Donaghy advised that there is currently no provision for this payment under AfC.	<i>K Donaghy – SMT 22 Sept 2010</i> <i>K Donaghy</i> <i>SMT 22 Sept 2010</i> <i>SMT 29 Sept 2010</i>

6	GOVERNANCE ISSUES 6.1 NIAO – 2009/10 Report to those Charged with Governance This item was discussed at SMT on 15 September 2010. 6.2 Blood Transfusion Policy Members noted the changes following discussion at SMT on 15 September 2010 and agreed same. 6.3 Thrombosis Committee – terms of reference This item was deferred to SMT on 22 September 2010. 6.4 Newborn Blood Spot Screening Programme Performance Report This item was deferred to SMT on 22 September 2010. 6.5 Unallocated Cases Mr Dornan referred members to the Unallocated Cases statistics which will be tabled at Trust Board on 30 September 2010. 6.6 Transforming Care at the Bedside Information Session – 11 November 2010 – HSC Safety Forum The Chief Executive referred to information regarding the forthcoming HSC Safety Forum and Directors confirmed that relevant staff would be attending.	<i>Dr Loughran SMT – 22 Sept 2010</i> <i>SMT – 22 Sept 2010</i> <i>Trust Board – 30 Sept 2010</i>
7	INFECTION CONTROL UPDATE 7.1 Weekly Hand Hygiene and Commode Audit Overview The Audit exemption reports with regard to hand hygiene and commodes were noted. 7.2 Environmental Cleanliness Weekly Exception Reports Members noted the environmental cleanliness exception reports. Directors to action as necessary.	

	7.3 Verbal Update on the Unannounced Hygiene Inspection at CAH on 14 September 2010 Dr Rankin provided a verbal update to members following the Unannounced Hygiene Inspection carried out at CAH on 14 September 2010. Dr Rankin advised that the inspection concentrated on the areas at A&E and Outpatients and noted the particular issues raised by the Team. Dr Rankin assured members that measures are in place to address the issues outlined. The Trust will await the formal report from RQIA. 7.4 HCAI Update Dr Loughran updated members on the current position with regard to HCAI within the Trust.	
8	CSR/CHANGING FOR THE BETTER – 5 YEAR STRATEGIC PLAN 8.1 Proposal for the Centralisation of Planned Paediatric Surgical Care & EIA – draft consultation report Members noted the further revised version of the Proposal for the Centralisation of Planned Paediatric Surgical Care. The final Trust Board version will be tabled at SMT on 22 September for endorsement prior to going to Trust Board. 8.2 Corporate Plan Mrs Clarke advised that the Corporate Plan will be tabled at the next SMT meeting on 22 September 2010.	<i>SMT – 22 Sept 2010</i> <i>SMT – 22 Sept 2010</i>
9	CAPITAL PRIORITIES/REVENUE BUSINESS CASES 9.1 Summary of Internal Capital Business Cases The summary of Internal Capital Business Cases was tabled and approval given by members. 9.2 Lurgan Hospital Refurbishment Mrs McVeigh referred to the paper regarding the Lurgan Hospital Refurbishment which outlines the options available for refurbishment works.	<i>Trust Board – 30 Sept 2010</i>

	Following consideration of the proposed options members agreed to implement option 2 – <i>refurbish ward 5 and relocate the Stroke Unit to Ward 5 on the first floor. Refurbish ward 7 and 8 and move ward 6 to 7 and 8. Refurbish ward 6 and move ward 4 to ward 6.</i> 9.3 Lurgan Hospital Lift Proposals Mrs McVeigh outlined to members the proposals for the lift at Lurgan Hospital and members discussed the option of a fire lift and agreed as the best way to move forward.	<i>Both: A McVeigh Approved</i>
10	WORKFORCE ISSUES 10.1 Legal Judgement: Working Time Regulations – verbal update Mr K Donaghy referred to the legal judgement regarding the working time regulations and advised that the recent appeal hearing has been overturned. 10.2 CEF – Federal Executive Institute 2011 – Leadership for a Democratic Society Programme Members noted the CED Federal Executive Institute Leadership programme. 10.3 Newspaper Article – Inquest into Junior Doctor Rota Review The Chief Executive referred members to the recent Newspaper Article following the inquest into Junior Doctors Rota Review in Taunton and Somerset NHS Foundation Trust. Members provided assurance that the Trust had sufficient safeguards in place, including Hospital at Night.	
11	SECTION 75 NI ACT 1998 Mrs Lynda Gordon attended the meeting to present to members Section 75 of the NI Act 1998. Mrs Gordon outlined the background and context to the equality scheme, highlighting areas of change and the statutory duty upon the Trust.	

	Members were advised of the requirement by Public Authorities to provide an action-based plan on how they would address this work. The finalised scheme and action plan is required to be submitted formally by 1 May 2011. Members agreed the importance of having a robust model to work to and it was agreed that a populated framework would be brought back to SMT in mid-October. Members thanked Mrs Gordon for a very comprehensive presentation.	
12	IMPLEMENTATION OF THE COMMUNITY DEVELOPMENT STRATEGY & ACTION PLAN 2005-09 Mrs McVeigh referred members to the Community Development Strategy & Action Plan for 2005-2009. Members noted and accepted the plan.	
13	OPERATIONAL ACTION PLAN TO ENHANCE PERSONAL & PUBLIC INVOLVEMENT WITHIN THE SHSCT – APRIL 2010 – MARCH 2011 Mrs McVeigh referred to the operational action plan to enhance Personal & Public Involvement within the Trust and advised that the plan provides an overview/summary of the high level trends and issues coming from Directorate PPI plans. Members agreed the importance of embedding into activity at ground level and the need to keep it simple and basic but yet measurable. Mrs McVeigh to continue to progressing this work.	<i>A McVeigh</i>
14	IMPROVING EMPLOYMENT OPPORTUNITIES FOR DISABLED PEOPLE – POSITION PAPER FOR APPROVAL Mr Donaghy referred members to the paper regarding Improving Employment Opportunities for Disabled People. He proposed 10 placements across a range of settings which are rotational. Members considered the content of the paper and agreed in principle to proceed.	<i>K Donaghy</i>

	Mr Donaghy to undertake a more detailed implementation plan.	
15	REVIEW OF TEENAGE PREGNANCY & PARENTHOOD STRATEGY & ACTION PLAN – TRUST RESPONSE FOR APPROVAL Mrs McVeigh referred to the completed draft response to the Teenage Pregnancy & Parenthood Strategy and Action Plan. Members considered and approved same for submission. Elaine Wright to submit by 17 September 2010.	<i>E Wright to submit by 17 Sept 2010</i>
16	WEEKLY COMMUNICATIONS TELECONFERENCE Members considered the content of the weekly communications teleconference.	
17	STAFF E-BRIEF Members noted the staff e-brief due to be circulated to all staff.	
18	ANY OTHER BUSINESS 18.1 Launch of Volunteer Now Bursary Scheme for the 2012 Olympics Mrs McVeigh raised with members the launch of the Bursary Scheme for Volunteers for the 2012 Olympics. The Chief Executive asked Mrs McVeigh and Mr Donaghy to prepare a proposal for the next SMT meeting on 22 September 2010. 18.2 Admin Review Mr Rice referred to the ongoing Admin Review and proposals arising from the review and the need to co-ordinate across Directorates. Members agreed the importance of synchronising across Directorates and agreed to take forward with a joint approach.	<i>K Donaghy/ A McVeigh – SMT 22 Sept 2010</i> <i>Mr Rice/ Dr Rankin</i>

	18.3 Performance Workshop Mrs Clarke advised that dates would be circulated shortly regarding a proposed performance workshop. 18.4 Internal Audit Programme for 2010/11 Mr McNally advised that the current year's programme for Internal Audit is due to commence and informed members that the Review of Travel Expenses would be one of the initial audits to take place. Members were reminded of the importance of timely submission of expense forms and the need to inform staff accordingly. In principle it was agreed that travel claims submitted after 3 months would not be processed. Mr McNally agreed to provide communication to staff regarding same.	<i>Mr McNally</i>
19	DATE OF NEXT MEETING The next SMT meeting will be held on Wednesday 22 September 2010 commencing at 2.00pm.	

Toal, Vivienne

From: Brennan, Anne <[redacted] Personal Information redacted by the USI >
Sent: 16 September 2010 14:26
To: [redacted] Colin Fitzpatrick email address
Cc: Donaghy, Kieran; McAlinden, Mairead; Loughran, Patrick; Hynds, Siobhan; Toal, Vivienne
Subject: Medical Leadership Network: 16.09.2010
Attachments: agenda_24sept2010-revised16sept2010.doc; Procedure for Handling Concerns about Doctors and Dentists Performance (MHPS) FINAL 15 September 2010.doc

Dear Colin –

Thank you very much for agreeing to lead the training afternoon on 24th September. I explained that this is part of an Associate Medical Director/Clinical Director Medical Leadership training programme and we are concentrating on performance concerns for doctors and dentists. In terms of the timetabled programme I can confirm that after the introductions and background we can give you about 1 hour to talk about the work of NCAS. I enclose the draft of our guidance in relation to this subject and following your presentation – as discussed, two senior members of our HR team will go through the principles within the guidance and how it links to maintaining high professional standards. After a short break we can then work through the 5 scenarios and expect to be finished around 4.30 I look forward to hearing to seeing you on the 24th.

Regards, Paddy

Anne Brennan

Southern Health & Social Care Trust

Tel: [redacted] Personal Information redacted by the USI
[redacted] Personal Information redacted by the USI
www.southerntrust.hscni.net



**Southern Health and Social Care Trust
Medical Leadership Network**

Friday 24th September 2010 at 1.30pm

Venue: Board Room, Trust Headquarters, Craigavon Area Hospital

Purpose:

This session provides an opportunity to explore how we handle performance concerns about doctors and dentists.

Programme

1.30 Welcome and Introductions – Christine McGowan

1.40 Background to Workshop Event – Dr P Loughran

1:50 NCAS – Dr Colin Fitzpatrick

2:50 Southern Trust Guidance on Handling Concerns about Doctors and Dentists – V Toal/S Hynds

3.10 Break

3:30 Case Studies via Group Work:

Scenario 1:

The Coroner expresses concern that an elective Aortic Aneurysm case was poorly managed resulting in the death of the patient. The Trust has been asked to look at the doctors competence. He is recently appointed. You are the AMD what action would you expect the Trust to take?

Scenario 2:

A member of the multidisciplinary team contacts you as AMD to express concern about the competency of a doctor who carries out procedures. They advise you that

they have already raised the concern with the Clinical Director who feels that no action is required. What steps do you take to address the team members concern?

Scenario 3

Your colleague and close friend turns up for work and smells strongly of alcohol. He explains that he was at a party the previous night. He insists that he is capable of working today. You know him well and you do not agree. What actions do you take? Does the Trust have policies to assist?

Scenario 4

In audit of antibiotic prescribing there is one paediatric nephrologist who does not follow the Trusts published antibiotic guidance. You are the Clinical Director – how would you manage this situation?

Scenario 5

The Trust's quarterly report which looks at Clinical Indicators suggests that there is an excess of morbidity in one doctors' practice [large number of admissions to ICU]. What actions should the Medical Director, Operational Director and AMD take?

4.30 Review and Close

In preparation for the workshop attendees have been sent a copy of the **Trust Guidance on Handling Concerns about Doctors and Dentists** to consider. If you have not received a copy of this, please contact Laura White at

Personal information redacted by USI

a copy will be forwarded to you.



Southern Health
and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

FINAL
15 September 2010

1.0 Introduction

1.1 Maintaining High Professional Standards in the Modern HPSS *A framework for the handling of concerns about doctors and dentists in the HPSS*

(hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.

1.2 The MHPS framework is in six sections and covers:

- I. Action when a concern first arises
- II. Restriction of practice and exclusion from work
- III. Conduct hearings and disciplinary procedures
- IV. Procedures for dealing with issues of clinical performance
- V. Handling concerns about a practitioner's health
- VI. Formal procedures – general principles

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This procedure, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
- b) Determine whether there is a continuing risk.
- c) Decide whether immediate action is needed to remove the source of the risk.
- d) Establish actions to address any underlying problem.

- 1.5** This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.
- 1.6** This procedure applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.
- 1.7** This procedure should be read in conjunction with the following documents:

Annex A

“Maintaining High Professional Standards in the Modern NHS”
DHSSPS, 2005

Annex B

“How to conduct a local performance investigation” NCAS, 2010

Annex C

SHSCT Disciplinary Procedure

Annex D

SHSCT Clinical Manager’s MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1** NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

- 2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.
- 2.3 MHPS (2005) states that **all** concerns must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.
- 2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

- 2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expeditiously as possible and the Oversight Group will monitor progress.
- 2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.
- 2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.
- 2.9 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1

An informal process. This can lead to resolution or move to:

Appendix 2

A formal process. This can also lead to resolution or to:

Appendix 3

A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

Appendix 4

An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5

Exclusion can be used at any stage of the process.

Appendix 6

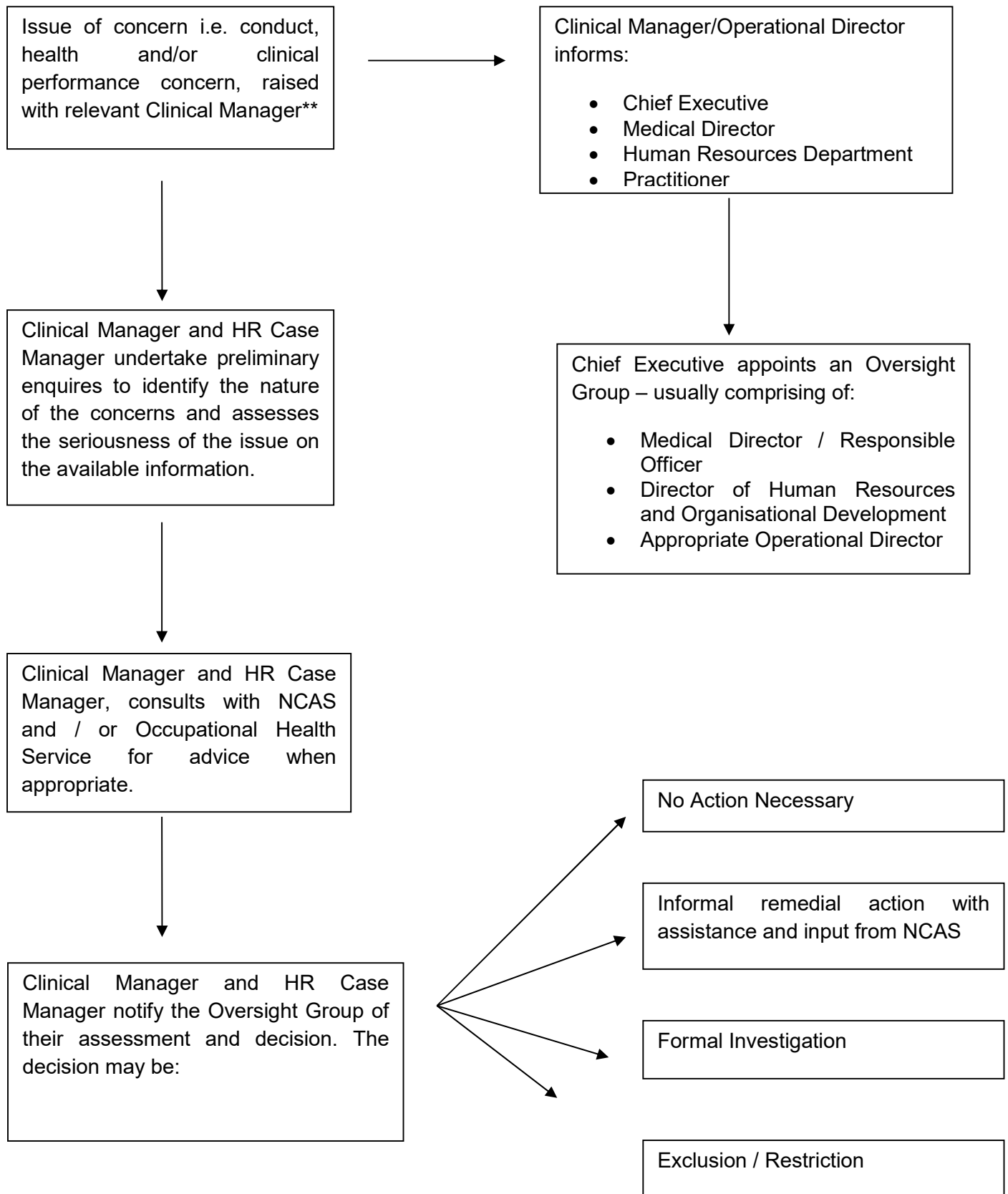
Role definitions

- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

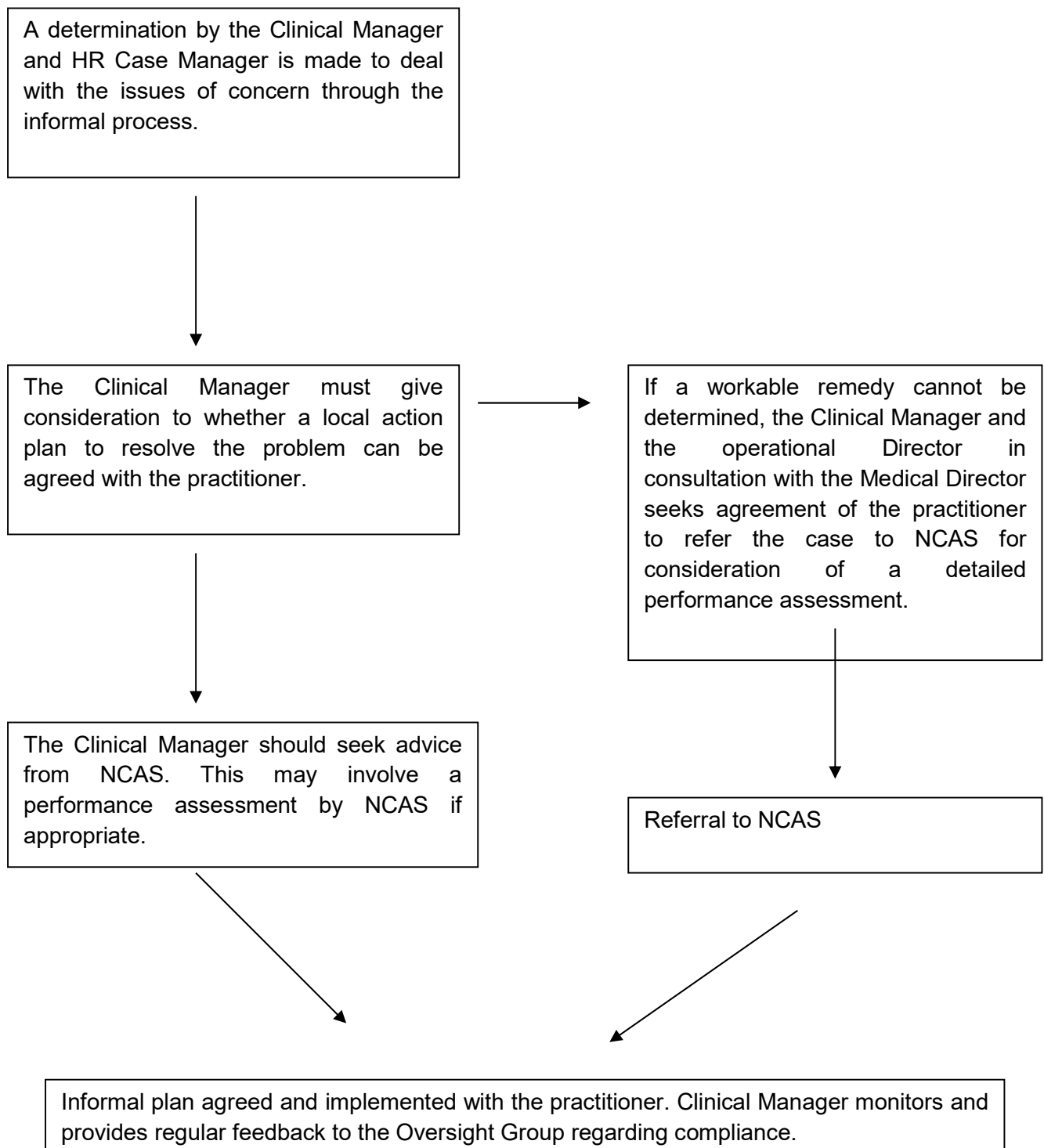
- 3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).
- 3.4 All formal cases will be presented to SMT Governance by Medical Director and Operational Director to promote learning and for peer review when the case is closed.
- 3.5 During all stages of the formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, 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 not acting in a legal capacity. Refer MHPS Section 1 Point 30.

Appendix 1

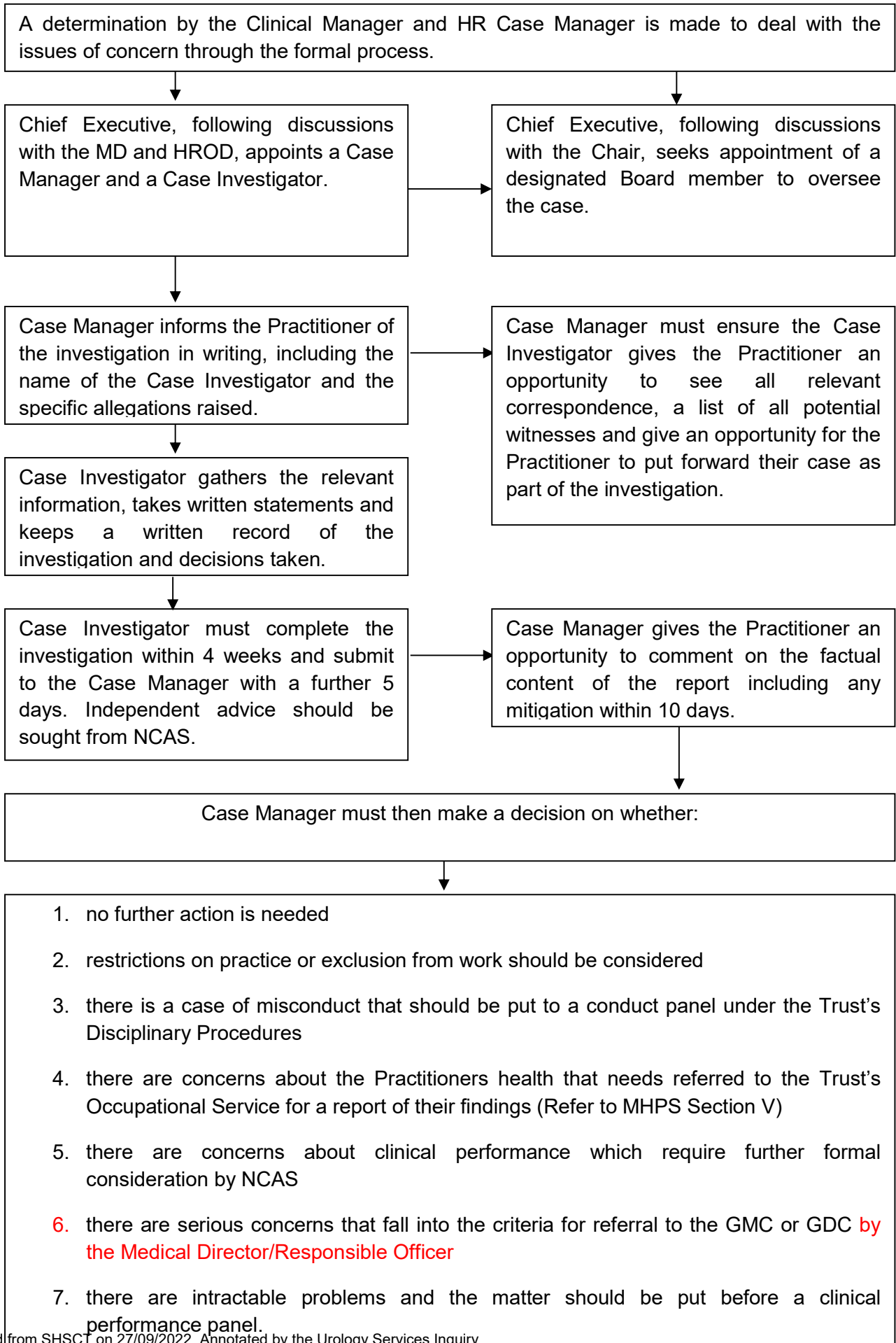
Step 1 Screening Process

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

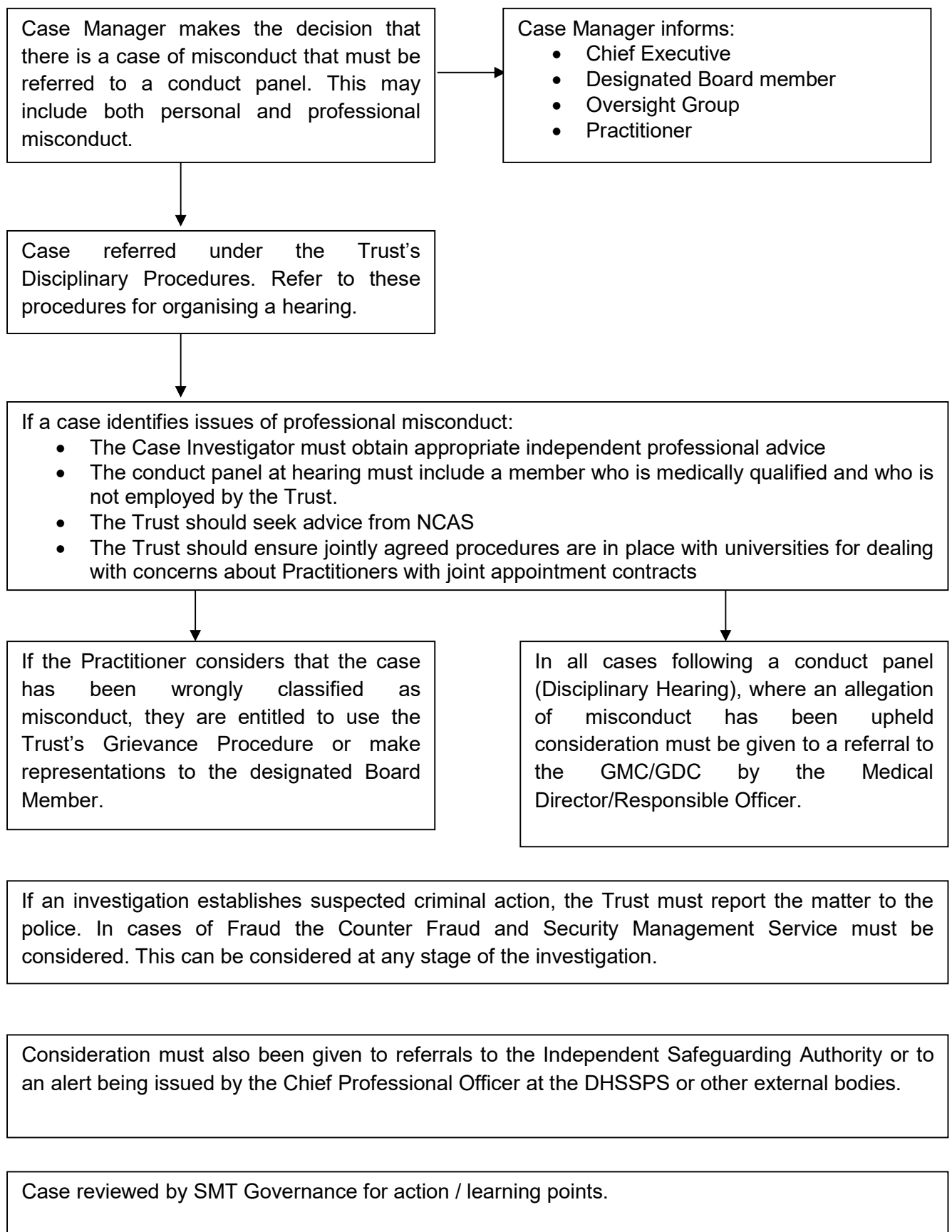
Appendix 1

Step 2 Informal Process

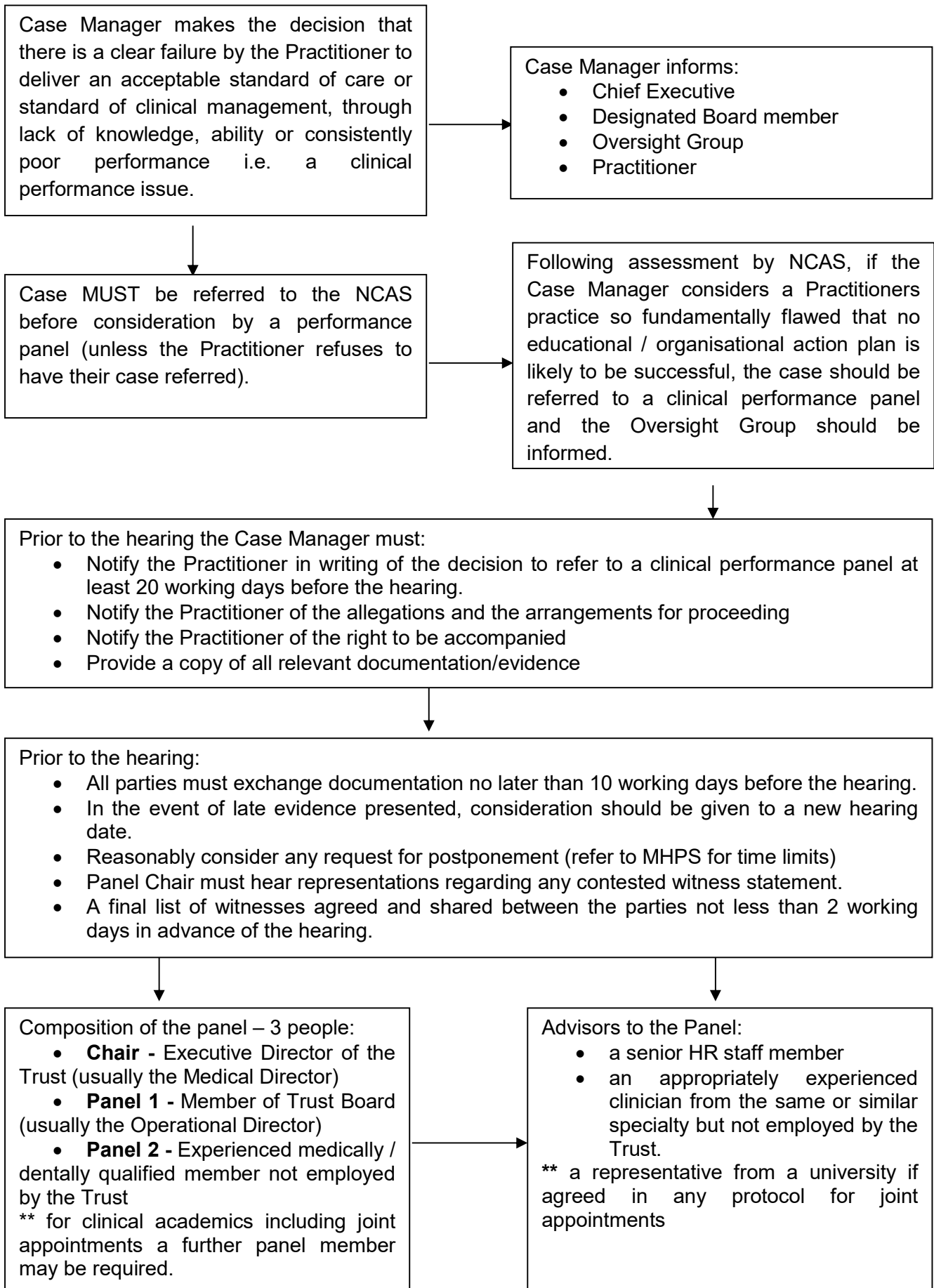
Appendix 2

Formal Process

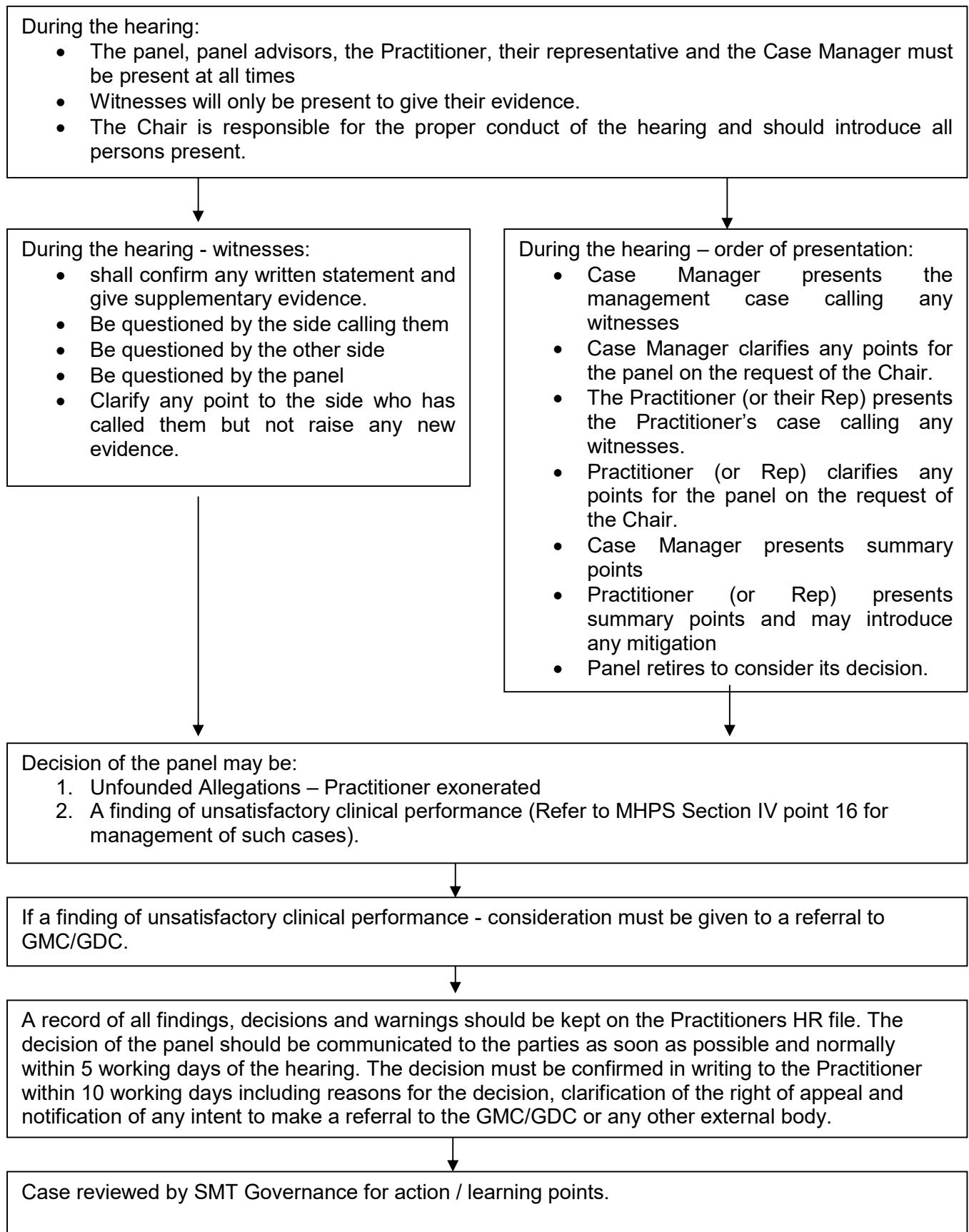
Appendix 3

Conduct Hearings / Disciplinary Procedures

Appendix 3a

Clinical Performance Hearings

Appendix 3a

Clinical Performance Hearings

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

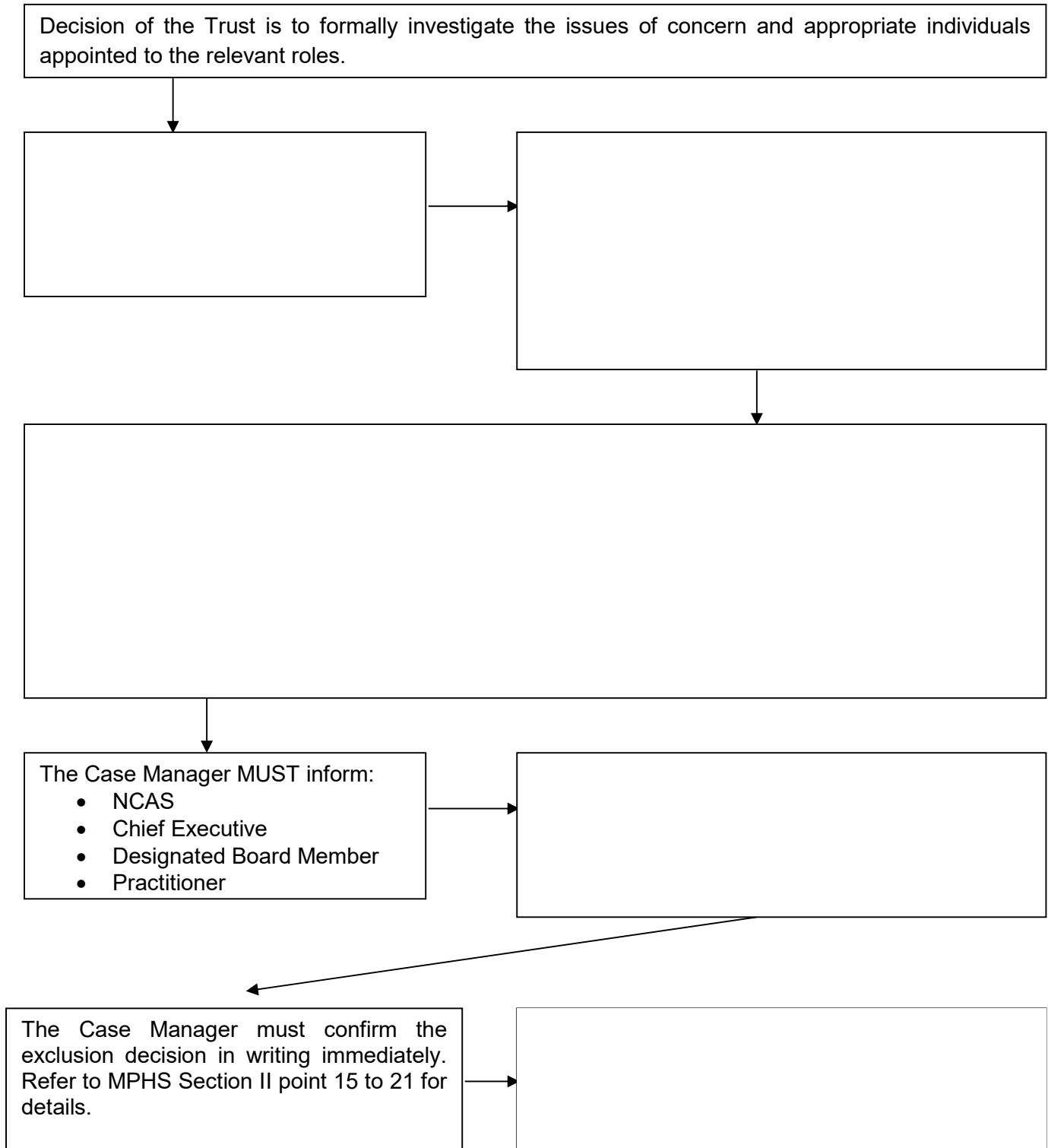
The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Restriction of Practice / Exclusion from Work**Formal Exclusion**

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.



Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

23 September 2010

1.0 Introduction

- 1.1 Maintaining High Professional Standards in the Modern HPSS**
A framework for the handling of concerns about doctors and dentists in the HPSS (hereafter referred to as Maintaining High Professional Standards (MHPS)) was issued by the Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction or suspension.
- 1.2** This document seeks to underpin the principle within the MHPS Framework that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patient's harmed.
- 1.3** The MHPS framework is in six sections and covers:
- I. Action when a concern first arises
 - II. Restriction of practice and exclusion from work
 - III. Conduct hearings and disciplinary procedures
 - IV. Procedures for dealing with issues of clinical performance
 - V. Handling concerns about a practitioner's health
 - VI. Formal procedures – general principles
- 1.4** MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.
- 1.5** This guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

- a) Ascertain quickly what has happened and why.
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1.6 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

1.7 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.8 This guidance should be read in conjunction with the following documents:

Annex A

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Annex B

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Annex C

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Annex D

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2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

- 2.1 NCAS Good Practice Guide – “How to conduct a local performance investigation” (2010) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. The Guide also indicates that anonymous complaints and concerns based on ‘soft’ information should be put through the same screening process as other concerns.
- 2.2 Concerns¹ should be raised with the practitioner’s Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.
- 2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.
- 2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.
- 2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

¹ Examples of Concerns may include: - when any aspect of a practitioner’s performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

- 2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

- 2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expeditiously as possible and the Oversight Group will monitor progress.
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informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

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- 2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.

Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

- 3.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

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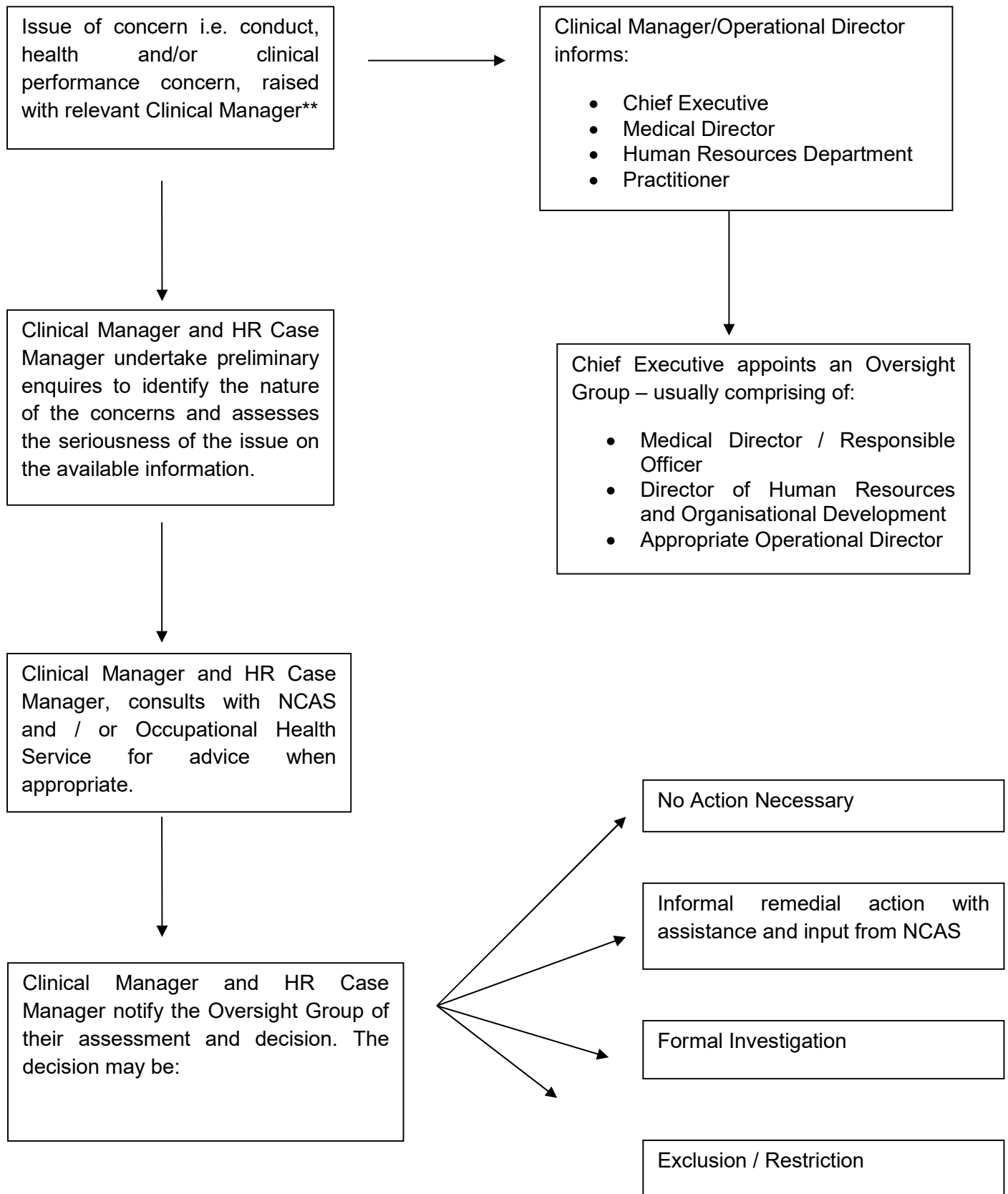
Exclusion can be used at any stage of the process.

Appendix 6

Role definitions

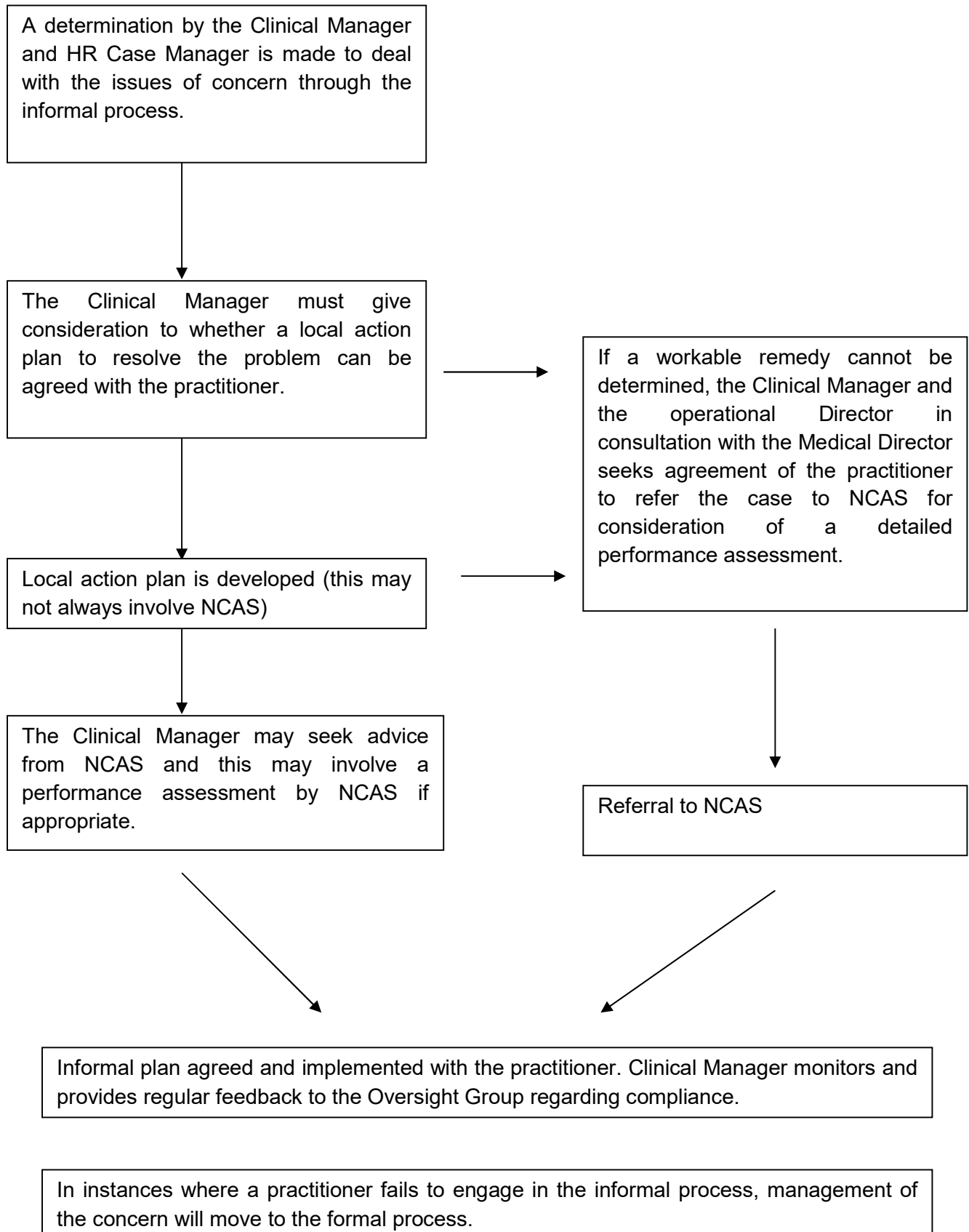
- 3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.
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- 3.4 All formal cases will be presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review when the case is closed.
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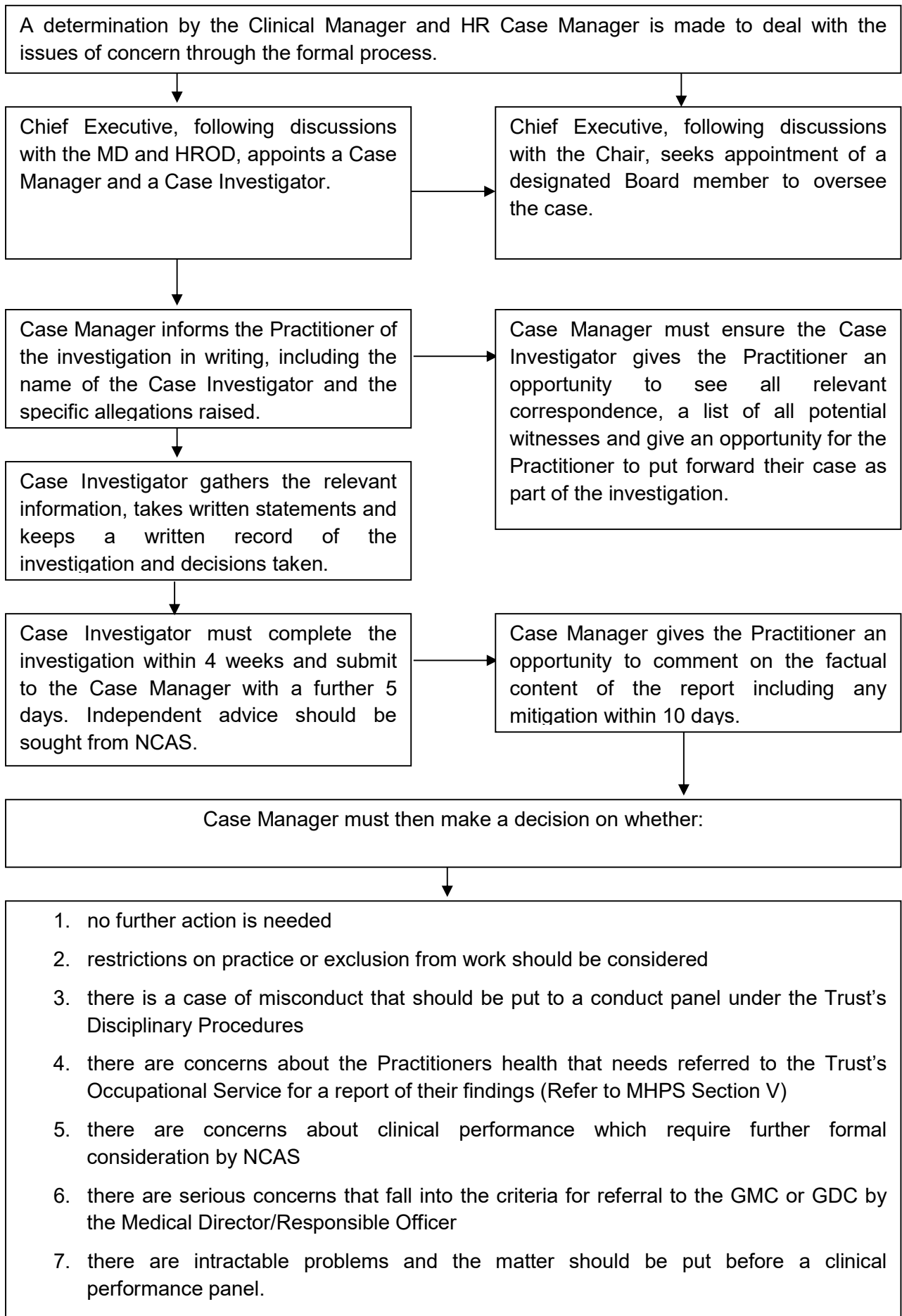
Step 1 Screening Process

** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

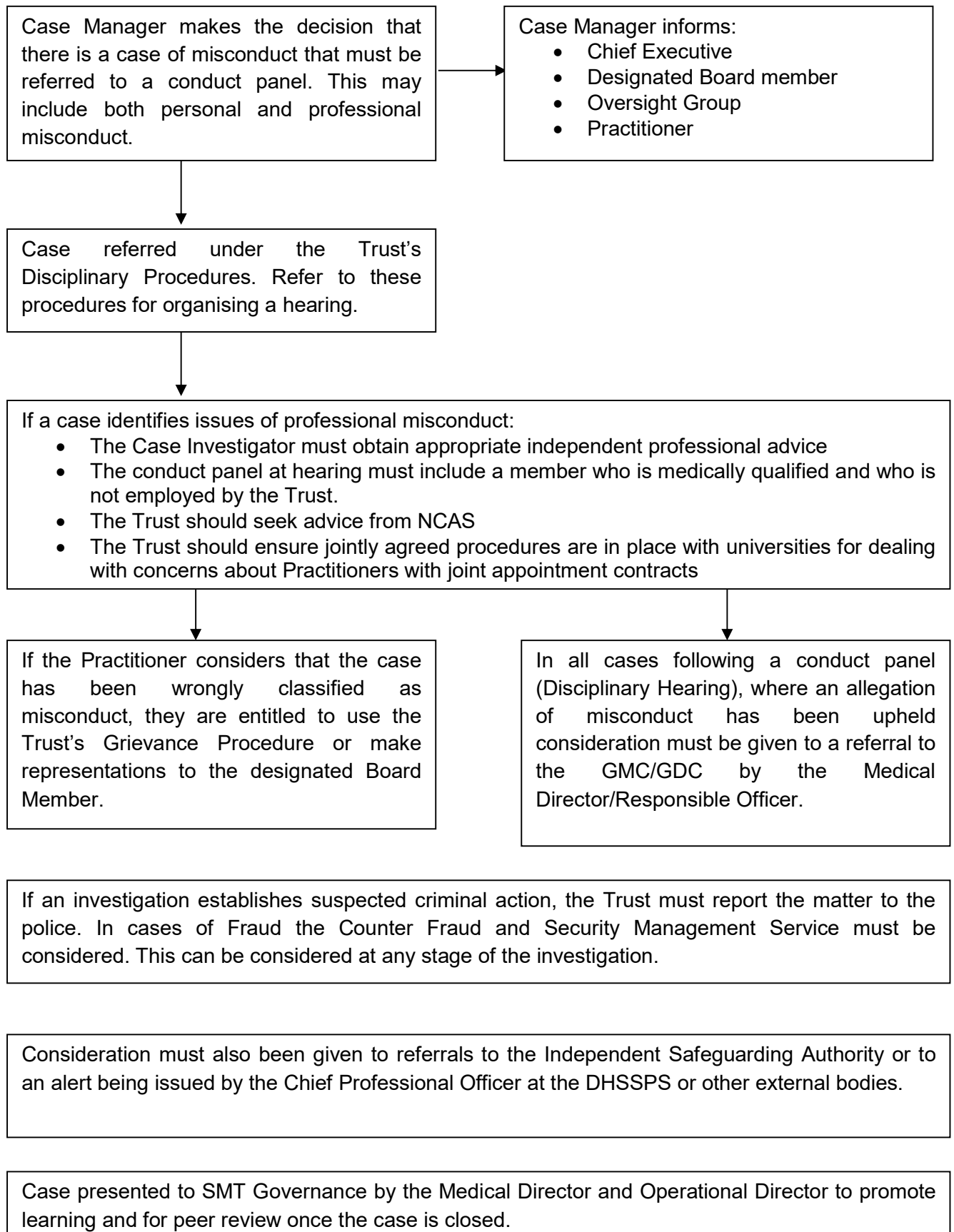
Appendix 1

Step 2 Informal Process

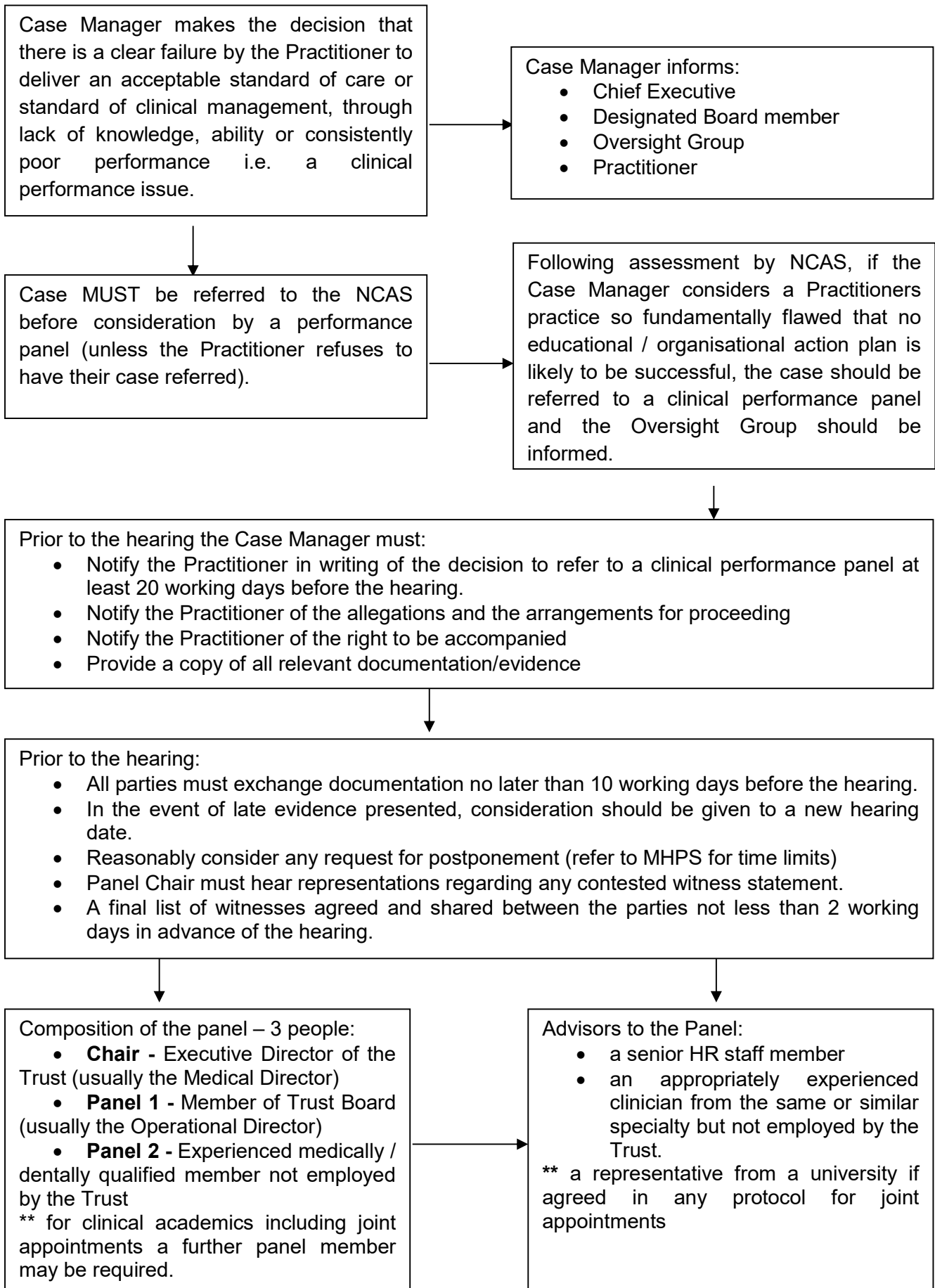
Appendix 2

Formal Process

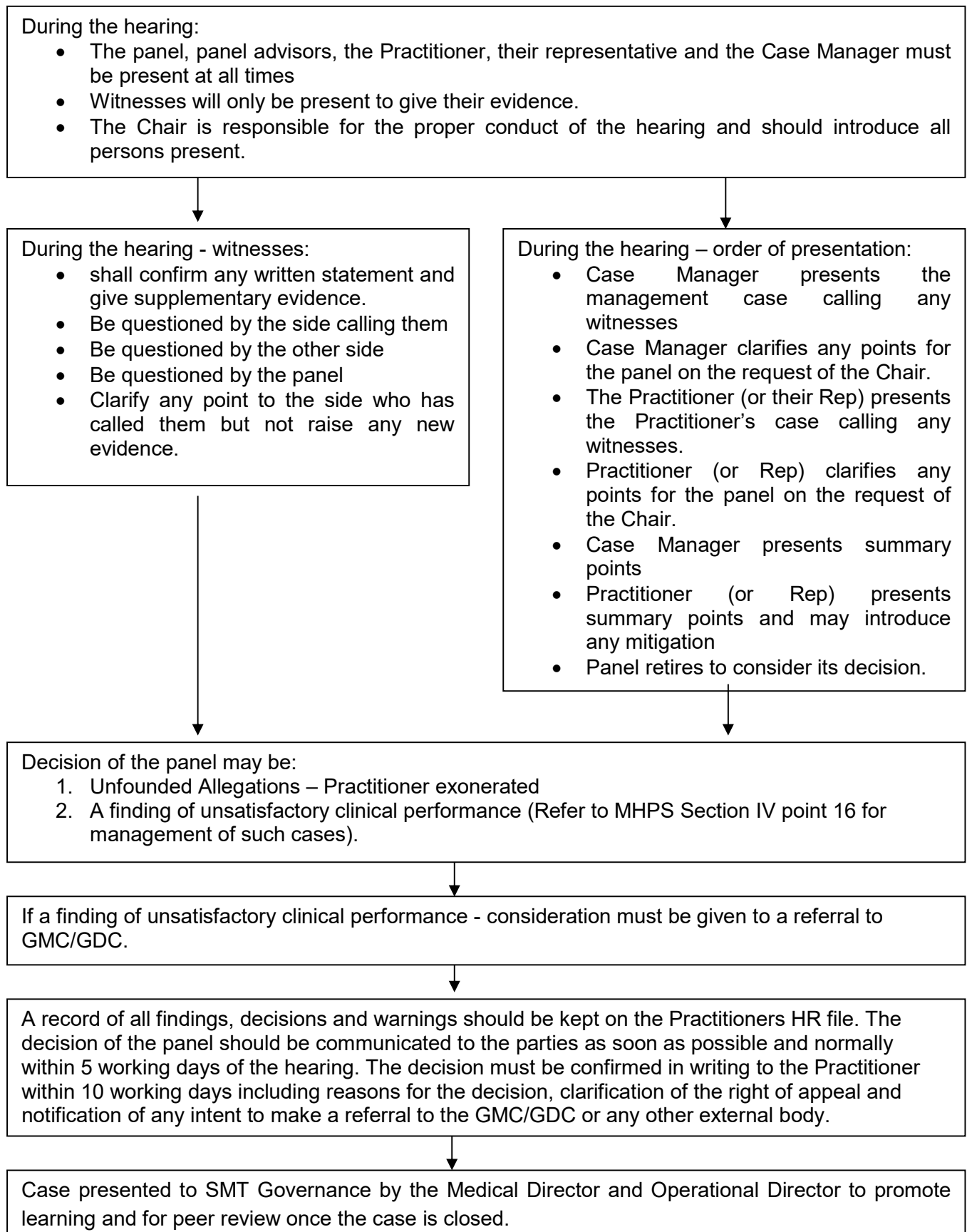
Appendix 3

Conduct Hearings / Disciplinary Procedures

Appendix 3a

Clinical Performance Hearings

Appendix 3a

Clinical Performance Hearings

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

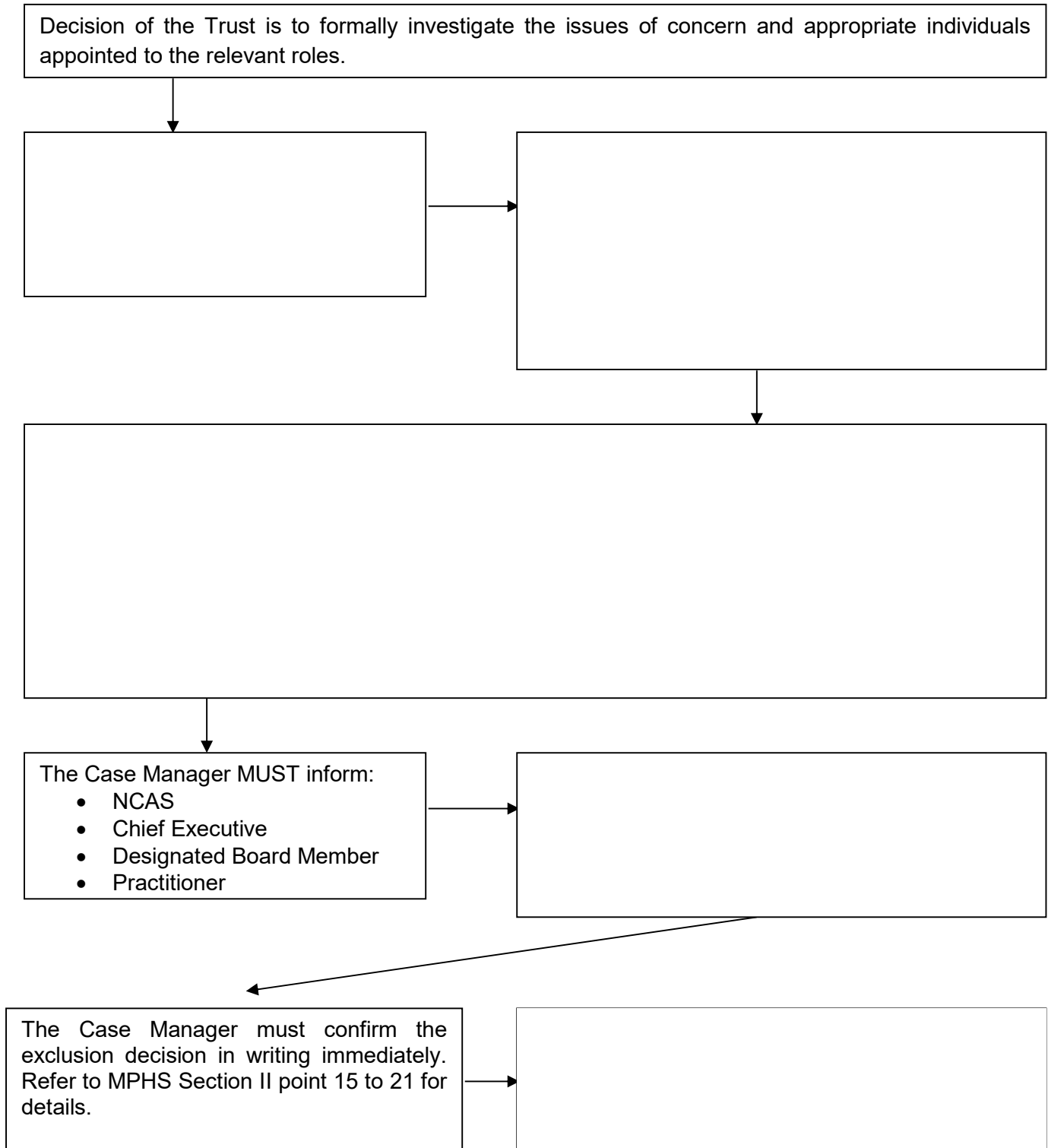
The exclusion should be sanctioned by the Trust's Oversight Group and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Restriction of Practice / Exclusion from Work**Formal Exclusion**

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

The Chief Executive in conjunction with the Oversight Group appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of formal the investigation and requests that a Non-Executive Director is appointed as "designated Board Member".

Case Manager

This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of the process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator

This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work.

Note: Should the concerns involve a Clinical Director, the Case Manager becomes the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager becomes the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust. Any conflict of interest should be declared by the Clinical Manager before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

Toal, Vivienne

From: S Hynds <[REDACTED]>
Sent: 23 September 2010 23:50
To: Toal, Vivienne
Cc: Hynds, Siobhan
Subject: Presentation
Attachments: Trust Guidelines for Handling Concerns about Doctors and Dentists Sept 10.PPT

Vivienne,

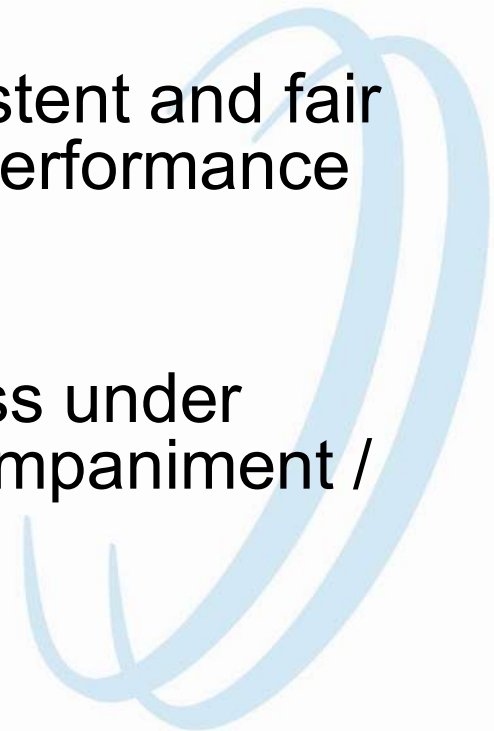
Presentation attached - the slides did not look right with just flowcharts on all of them so I have extracted some of the most important points under each heading and will just talk through the flow charts- are you happy with this?

How are you getting on?

Siobhan

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

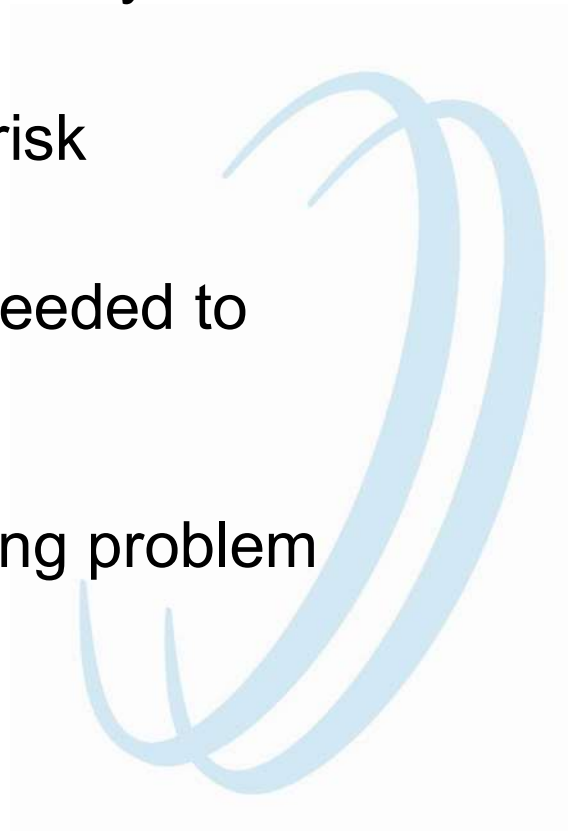
Principles:

- the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patient's harmed.
 - the guidelines aim to ensure that a consistent and fair approach is adopted for the handling of performance concerns within the SHSCT.
 - that during all stages of the formal process under MHPS, the practitioner is entitled to accompaniment / representation.
- 

Response to concerns

Whatever the source of the concern, the response must be the same i.e. to:

- Ascertain quickly what has happened and why
- Determine whether there is a continuing risk
- Determine whether immediate action is needed to remove the source of the risk
- Establish actions to address any underlying problem



Initial Concern Arises

- Concerns should be raised with the Practitioner's Clinical Manager
- The Clinical Manager should inform the relevant Operational Director who will inform the Chief Executive and the Medical Director
- The Clinical Manager must seek advice from a nominated HR Case Manager
- The Clinical Manager and the HR Case Manager will undertake initial verification / fact finding
- The Chief Executive is responsible for appointing a Trust Oversight Group
- Practitioner must be informed of the concerns by the Clinical Manager

Screening Process

- Clinical Manager and HR Case Manager will investigate the concerns raised and assess what action should be taken in response
- the Oversight Group is informed of the possible action to be taken which may be:
 - No action
 - Informal remedial action with input from NCAS
 - Formal Investigation
 - Exclusion / Restriction



Informal Process

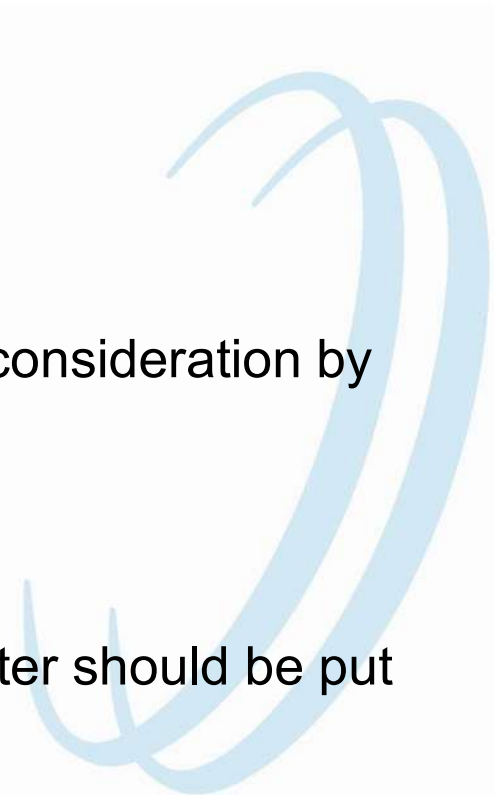
- Local action plan developed and agreed with the practitioner
- Advice may be sought from NCAS / Occupational Health
- If a remedy cannot be determined, agreement of the practitioner sought to refer the case to NCAS
- Informal plan agreed, implemented and monitored
- Failure on the part of the practitioner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

Formal Process

- Chief Executive appoints a Case Manager, Case Investigator and a designated Board member
- Case Manager informs Practitioner of the specific allegations and the name of the Case Investigator
- Investigation report compiled within designated timeframes
- Practitioner able to comment on the report and should be kept fully informed
- Case Manager responsible for deciding on the appropriate course of action based on the Case Investigator's report

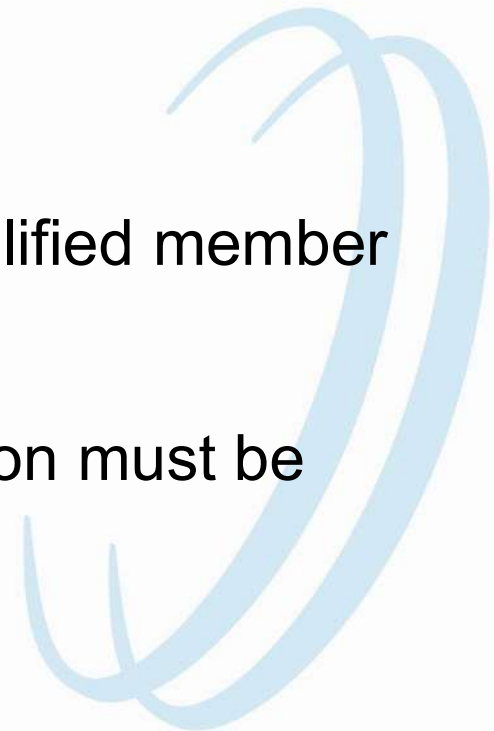
Formal Process – Decisions

The Case Manager has a range of decisions available:

- No further action required
 - Restrictions / Exclusion from work
 - Conduct Panel
 - Referral to Occupational Health
 - Clinical performance concerns which require further consideration by NCAS
 - Serious concerns which are referred to GMC/GDC
 - Clinical performance is so fundamentally flawed, matter should be put before a clinical performance panel
- 

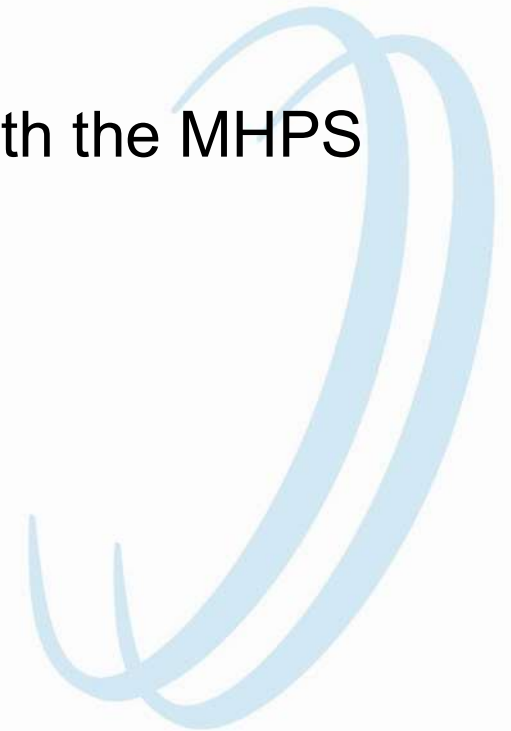
Conduct Hearings

- Misconduct (including professional misconduct) concerns to be referred under the Trust's Disciplinary Procedures
- Independent professional advice should be sought in cases of professional misconduct
- NCAS advice to be sought
- Conduct panel must include a medically qualified member not employed by the Trust
- If the misconduct case is upheld consideration must be given to a referral to GMC/GDC



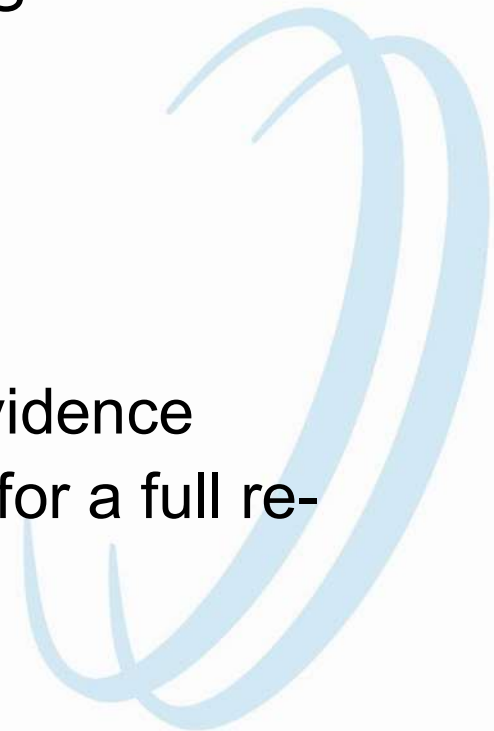
Clinical Performance Hearings

- Case MUST be referred to NCAS before consideration by a clinical performance panel
- Practitioner must be informed of all relevant information prior to the hearing and within the identified timeframes under MHPS
- Panel must be constituted in accordance with the MHPS framework
- Clinical Performance panel may decide:
 - Unfounded allegations
 - Unsatisfactory clinical performance



Appeal Procedure

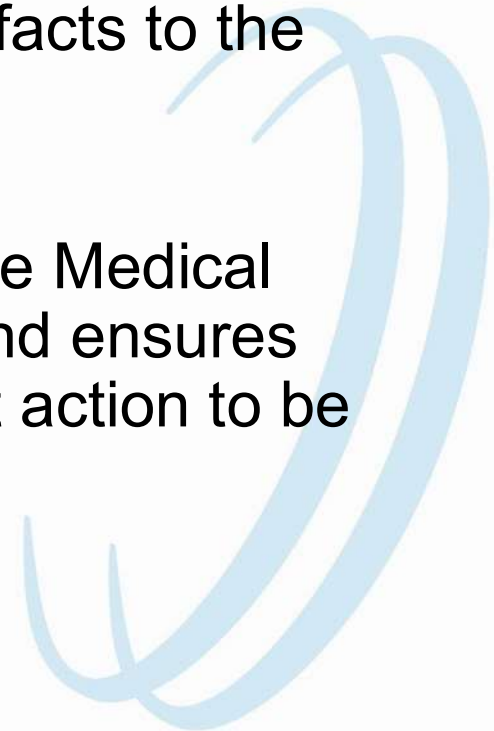
- Appeal panel must be constituted in accordance with the MHPS framework
- Appeal submissions must be made and hearing convened within the identified timescales under MHPS
- The Appeal Panel can:
 - Vary or confirm the original decision
 - Seek information from own witnesses
 - Adjourn hearing to seek new statements/evidence
 - Refer to a new Clinical Performance panel for a full re-hearing if appropriate



Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure
- Exclusions may be no more than 4 weeks
- Immediate Exclusion (when concern first arises) – NCAS should be notified
- Formal Exclusion (during formal investigation) – Trust case conference should be convened
- Restrictions should always be considered as an alternative to exclusion

Roles and Responsibilities

- Clinical Manager – will usually be the Clinical Director and point of contact for concerns to be raised. Will undertake initial screening of the concern
 - Case Investigator – will usually be the Clinical Director. Will examine the relevant evidence and present facts to the Case Manager
 - Case Manager – will usually be the Associate Medical Director. Will co-ordinate the investigation and ensures timescales are met. Determines the relevant action to be taken following an investigation
- 

Toal, Vivienne

From: Vivienne Toal <[REDACTED]>
Sent: 23 September 2010 23:45
To: Siobhan Hynds
Subject: Presentation - see attached.
Attachments: Medical Leadership Network Presentation 24.9.10.ppt

Siobhan

See attached - hopefully this is ok.

Talk to you in the morning.

Personal information
redacted by USI

V

Medical Leadership Network

Handling concerns about Doctors and Dentists

Vivienne Toal – Head of Employee Relations

Siobhan Hynds – HR Manager

Employee Relations Department



Quality Care - for you, with you

Handling concerns in relation to...

- Working relationships
- Attendance at work
- Personal and professional misconduct
- Clinical Performance

Working Relationships – Working Well Together Policy

- It is not a requirement to like or be friendly with work colleagues, however the WWT Policy states that it is essential that staff behave appropriately and treat each other with respect.
- Managers have a specific duty to be vigilant to the behaviour of staff within their team and are responsible for addressing actions that might cause offence to others.
- Managers must make every effort to ensure that conflict does not arise within their teams, or promptly deal with it if it does.
- Procedure outlines informal and formal processes for handling working relationship difficulties, including mediation.
- Formal process can result in disciplinary action being taken.
- Where the conflict has an equality dimension to it – Harassment at Work Procedure is used.



Southern Health
and Social Care Trust

Attendance at work -

Management of Sickness Absence Procedures

- Considerable cost of absenteeism requires us to manage it much more effectively
- Managers must monitor and manage sick leave within their teams in line with Trust Procedures
- Recording of sick leave episodes must be completed on Staff Absence Return Form and forwarded to Payroll & HR
- Proactive management of short term absence – 3 periods of absence in a rolling 12 month period is a potential cause for concern and trigger to consider if action should be taken
- Attendance Management Team in Employee Relations Department available for support and advice to managers

Personal & Professional Conduct

– Disciplinary Procedure

- Issues of personal or professional misconduct are dealt with under the Trust's Disciplinary Procedure
- Examples – theft, fraud, falsification of patient records, physical violence / assault
- Disciplinary investigations and hearings for medical / dental staff are undertaken in same way as for other staff, but reference to particular requirements for panel composition as directed under MHPS Framework.

Clinical Performance

- New Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance have now been developed
- This guidance establishes clear processes for how the Trust will handle concerns about its doctors and dentists in line with the Maintaining High Professional Standards Framework.

HR Support to clinical managers for dealing with concerns

- Employment Law and Case Management Team within Employee Relations deal with all cases
- HR Advisors support and advise managers in relation to all employee relations cases
- Siobhan Hynds manages the team and will allocate an HR Advisor to work with Clinical Managers on employee relations cases

Toal, Vivienne

From: Vivienne Toal <[Personal Information redacted by the USI]>
Sent: 24 September 2010 00:00
To: S Hynds
Cc: Siobhan Hynds
Subject: RE: Presentation
Attachments: Medical Leadership Network Presentation 24.9.10.ppt

Siobhan - these look 100% - very happy with format.

I've attached the 7 introductory slides - I've also sent them to your work email address about 10 mins ago. Can you merge in the morning?

Thanks a million

See you tomorrow.

V

From: S Hynds [Personal Information redacted by the USI]
Sent: Thu 23/09/2010 23:50
To: Vivienne Toal
Cc: Siobhan Hynds
Subject: Presentation

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Siobhan Hynds – HR Manager

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WIT-58426



National Patient Safety Agency

National Clinical Assessment Service

How to conduct a local performance investigation



Contact NCAS

For general enquiries, please contact our main switchboard on 020 7062 1620. Contact details for case referrals are:

England

1st Floor, Market Towers, 1 Nine Elms Lane, London SW8 5NQ

ADVICE LINE: 020 7062 1655

General switchboard: 020 7062 1620

Fax: 020 7084 3851

Northern Ireland

Lisburn Square House, Office Suite 2, 10 Haslem's Lane, Lisburn BT28 1TW

ADVICE LINE: 029 2044 7540

General switchboard: 028 9266 3241

Fax: 028 9267 7273

Scotland

Hanover Buildings, 66 Rose Street, Edinburgh EH2 2NN

ADVICE LINE: 0131 220 8060

General switchboard: 0131 220 8060

Fax: 0131 220 8950

Wales

First Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff CF10 4DQ

ADVICE LINE: 029 2044 7540

General switchboard: 029 2044 7540

Fax: 029 2044 7549

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Introduction

Purpose

The National Clinical Assessment Service (NCAS) is often asked for advice about local investigations into practitioner performance or conduct. While there are no firm rules about when to investigate or how, as each case has to be considered in relation to its own facts and circumstances, there are principles which can be followed in all sectors of healthcare and for any healthcare profession.

Identifying and dealing with performance problems promptly and efficiently can reduce potential risk for patients, practitioners and the teams they work in, as well as for the service as a whole. This guide suggests what this might mean for investigations. It follows the sequence of an investigation from first notification of a concern to the point at which findings are made available to decision-makers. It is written for both primary care organisations (PCOs) and organisations providing hospital and community (H&C) services, in both the NHS and independent sectors of healthcare.

Assumptions

As part of its governance programme, every organisation should have performance procedures which are objective, fair, up-to-date and easily accessed by anyone interested in them. Formal procedures should comply with core legislation and guidance. Organisations should aim to have managers trained to use the procedures and people identified as potential investigators and case managers so that investigations can proceed promptly, when needed. By assuming that local procedures and processes are in good order, this guidance can focus specifically on the investigating process. Other NCAS publications and guidance can be used to review local processes, if necessary, and managers can also ask NCAS advisers for help.

We have also assumed an understanding that guidance of this sort can cover only general principles and that the handling of a specific case must depend on the unique facts of that case. Where template formats are shown, these are illustrations of the types of issues and actions to consider; organisations should take legal advice, where necessary.

Relationship with other NCAS guidance

This guidance is written to be used alongside other NCAS publications including *Handling performance concerns in primary care* (2010). We have built on earlier NCAS guidance in *Local GP Performance Procedures* (2007) (now replaced by *Handling performance concerns in primary care*) and also on the joint Department of Health and NCAS publication *Handling Concerns About The Performance of Healthcare Professionals: Principles of Good Practice* (2006).

Further NCAS guidance can be downloaded from: www.ncas.npsa.nhs/toolkit

For current NCAS publications go to: www.ncas.npsa.nhs.uk/resources/publications/key-publications

Terms

'Organisation': a healthcare organisation employing or contracting with health practitioners.

'Investigation': an inquiry carried out by a healthcare organisation into whether or not there is a problem to address in a practitioner's performance.

'Practitioners': dentists, doctors and pharmacists, the groups within NCAS' current remit, although organisations may find the guidance useful in other contexts as well.

'Performance concerns': any aspects of a practitioner's performance or conduct which:

- pose a threat or potential threat to patient safety;
- expose services to financial or other substantial risk;
- undermine the reputation or efficiency of services in some significant way;
- are outside acceptable practice guidelines and standards.

A glossary of other terms can be found on page 23.

Legal framework

Statutory Instruments ('regulations') and frameworks differ from country to country and across the professions, so it is important to access the relevant legislation and guidance. The 'Must knows' sections on the NCAS website provide quick links to key NHS legislation in each country and for each practitioner group.

See www.ncas.npsa.nhs.uk/mustknows

Feedback

Feedback about this document would be greatly valued. Please send it to: ncas@ncas.npsa.nhs.uk

This is a guidance document but NCAS can be contacted at any stage for advice about the handling of specific cases.

1. Deciding whether to investigate

Performance concerns can come to light in many ways, including routine monitoring of management information, reports from patients and colleagues, appraisal, reports on serious untoward incidents and anonymous complaints or concerns. Anonymous reports may be difficult to verify but should not be dismissed. It is unlikely that on their own they would support formal action, but they may lend support to other evidence.

Any performance concern raises the possibility of a need for further investigation. This section outlines how to decide whether to conduct an investigation, by asking:

- What is a performance investigation?
- How might concerns be screened for investigation?
- What should be considered in making a decision to investigate?
- What are the alternatives?
- When is an investigation likely to be appropriate?

1.1 What is a performance investigation?

The purpose of a performance investigation is to determine whether or not there is a performance problem requiring action. A performance investigation is not a free-ranging inquiry. It is normally helpful to define the purpose of the investigation using terms of reference.

Terms of reference have to be determined based on what is known at the time an investigation is set up. If, later, a substantial issue comes to light that is outside the initial terms of reference, the terms can be reviewed and, if necessary, changed to ensure that the investigation covers the new issue.

An investigation report then sets out findings and the evidence on which the findings are based. The report informs a decision on whether to take action on the concern and how. It does not make the decision.

A decision to investigate commits the organisation to significant work and expense, so the organisation needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

1.2 How might concerns be screened for investigation?

Regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. Anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

The form that screening takes will vary from organisation to organisation. The essential requirement is that a consistent process is followed, with decisions made by a person or group with appropriate authority. Decisions made should be appropriately recorded and the practitioner kept informed of progress.

In *Handling performance concerns in primary care*, NCAS suggests the use of a decision-making group (DMG) supported by a professional advisory group (PAG), with membership suggestions made for both groups. In a primary care organisation (PCO) using this structure the DMG would usually make the decision to commission a local investigation or to take some other action such as referral to the police or counter fraud agency. In secondary care, it is the designated responsible manager (often the medical director or deputy) who will determine (in consultation with others, as appropriate) whether or not an investigation is required. In both sectors, the interface with responsible officers for medical practitioners (once appointed) will need to be considered.

The purpose of screening is to identify whether there are *prima facie* grounds for an investigation and, if there are, to set terms of reference which are sufficiently detailed for the investigation to proceed. It is essential that managers set aside dedicated time to progress initial screening so that it can be completed properly and quickly.

1.3 What should be considered in making a decision to investigate?

Before deciding whether a performance investigation is necessary, consider what other relevant information is available. This could include:

- clinical or administrative records;
- serious untoward incident reports or complaints;
- earlier statements or interviews with people with first-hand knowledge of the concern;
- clinical audit and clinical governance data;
- the views of appropriate professional advisers;
- earlier occupational health reports.

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

There will normally need to be input from the practitioner too. As a general principle, NCAS encourages employers and contracting bodies to be transparent and to communicate and engage early with the practitioner whose performance is causing concern. NCAS suggests that the case manager or other appropriate person should have a preliminary meeting with the practitioner, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses. The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police advise that early meetings or early disclosure could compromise subsequent investigations. But generally, the practitioner's response will be helpful in deciding whether to carry out an investigation.

1.4 What are the alternatives?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the following circumstances:

- The practitioner may agree that the concerns are well-founded and agree to cooperate with required further action. However, if the issues raised are serious enough to suggest that if upheld they might warrant consideration of termination of employment or removal from a performers list, then the organisation may still need to conduct an investigation. The action to be taken subsequently would then be decided in the normal manner.

- Confirmed or suspected ill-health is another situation where performance investigation could be inappropriate. But health problems may be part of a more complex presentation where an investigation could still be helpful, so ill-health does not, by itself, rule out investigation. Information on a practitioner's health problems should remain confidential unless there are exceptional circumstances that require disclosure in the public interest.
- An investigation may also be judged unnecessary if the concerns are being investigated by another agency. An external investigation does not automatically preclude an NHS investigation but the organisation should have reasons for carrying out its own investigation into different aspects of potentially the same concern. There should then be close liaison with the other agency to avoid one investigation being compromised by the other.

The decision to proceed or not proceed with an investigation should be documented, with reasons, along with decisions on any alternative actions decided on. Box 1 shows what a meeting note might look like for a meeting where the decision is to defer investigation for the time being and take action straight away.

Box 1 – Recording a decision not to investigate, in primary care

This note sets out who decided what and why, and what has to happen next and when, with the note signed as a correct record by the chair. Similar records should be kept by the responsible manager in secondary care, showing the advice taken and the decisions made.

Note of meeting to consider whether to carry out an investigation into the performance of [practitioner] held on [date]

PRESENT: []

[Member] said that he knew [practitioner] through common membership of the local representative committee but he did not believe there was a conflict of interest. It was agreed that [member] should continue to take a full part in the proceedings.

The circumstances of the concern were then summarised by [the responsible manager]. The following information had come to the [organisation]'s attention, suggesting that [practitioner] might be performing below an acceptable standard in relation to [specified aspects of care]:

- Information from patients/carers [summarised, anonymised].
- Information from management monitoring sources [summarised].
- Information from colleagues/staff [summarised, anonymised].
- Other information [summarised, anonymised].

[Responsible manager] advised that there were no immediate reasons for thinking that patient safety was at risk. Also, [practitioner] was aware of the organisation's concerns and had indicated a willingness to undergo a remedial training programme on [aspect of care].

Remedial training arrangements have still to be established with [the postgraduate deanery] but similar measures have been used successfully in similar cases of performance concern within the organisation

It was agreed that:

1. The concerns are already clearly enough understood for action to be taken.
2. Provided remedial training can be put in place, further investigation is unnecessary at this time. This will be taken forward by [the responsible manager] working with [].
3. The case should be reviewed after [] months.
4. No immediate action is needed to protect patient safety.

Signed as a correct record by [Chair]

Date

1.5 When is an investigation likely to be appropriate?

Investigation will usually be appropriate where case information gathered to date suggests that the practitioner may:

- pose a threat or potential threat to patient safety;
- expose services to financial or other substantial risk;
- undermine the reputation or efficiency of services in some significant way;
- work outside acceptable practice guidelines and standards.

In these situations, a well-undertaken investigation and report will probably help to clarify any action needed.

In deciding to go ahead with an investigation the screeners and decision-makers should have a clear view on the areas of performance that are a concern – what is to be included and what is to be excluded. The decision-makers might not draft the terms of reference but they should approve them before the investigation starts. The terms of reference should also set report expectations and timescales.

The process of deciding whether to hold an investigation is summarised in Box 2.

Box 2 – Checklist for deciding whether to investigate

	Responsibility	Date
Concern identified and referred to responsible manager	Anyone	
Practitioner normally notified of concern	Responsible manager	
Written confirmation to practitioner	Responsible manager	
First meeting with practitioner	Responsible manager	
Meeting date agreed for decision-making group (if applicable)	Responsible manager	
Additional information assembled	Responsible manager	
Decision made on whether to investigate	Responsible manager or decision-making group	

2. Protecting and supporting

Chapter 1 ended with the decision to investigate. Before the investigation can proceed, even to the planning stage, certain protections must be considered for the people who will be involved in the investigation in any capacity. A formal investigation of practitioner performance is likely to impact on patients, carers, other healthcare workers, the practitioner's staff and colleagues, expert and other witnesses, not to mention the managers carrying out the investigation. Each needs some level of protection or support while the investigation is under way. Organisations should, as appropriate:

- protect patients from harm;
- protect people raising concerns;
- keep patients informed;
- support the practitioner;
- protect the organisation.

2.1 Protect patients from harm

Depending on the facts of a particular case it may be necessary to consider formal suspension (in primary care) or exclusion (in secondary care). Where possible, discuss such cases with NCAS before taking action. NCAS provides a 24-hour, seven day a week service to deal with situations of this sort. Specific procedures must be followed to ensure that a suspension or exclusion is lawful.

Suspension or exclusion should only be used where there is no reasonable alternative. These measures are often described as 'neutral' acts intended to protect patients, staff and the practitioner, and not to be disciplinary sanctions. In practice, the practitioner – and possibly colleagues – may see them differently. While exclusion or suspension do protect patients, they can make performance improvement more difficult.

As alternatives, an organisation might:

- ask the practitioner to withdraw voluntarily from carrying out certain duties;
- offer suitable alternative NHS work away from direct patient contact, whilst investigations continue.

Voluntary agreements should be put in writing. They should only be used as an alternative to formal action if detailed, clear and robust enough to give the same certainty of protection as formal action. A voluntary agreement could also state explicitly that the practitioner is entering into a formal undertaking which, if breached later, might lead to referral of the practitioner to the professional regulator. For non-contractor pharmacists, voluntary agreements remain the only available mechanism to restrict their practice.

Discussion with NCAS is advisable before use of a voluntary agreement to restrict practice. The practitioner should be advised to consult a defence society, union or solicitor before signing. Voluntary agreements are not appropriate where there are significant health difficulties or dishonesty is suspected. Apart from anything else, they may compromise an organisation's ability to take a formal position later that the practitioner was not fit to practise. Any information related to a practitioner's health or personal circumstances should normally remain confidential.

For the legal frameworks governing suspension and exclusion in each country go to www.ncas.npsa.nhs.uk/mustknows. Local guidance, regulations and ministerial directions (for example in England, *Maintaining High Professional Standards in the Modern NHS* (MHPS), Department of Health 2003) specify how practitioners must be notified that suspension or exclusion is being considered and given opportunity to make any representations.

For an outline voluntary undertaking to restrict practice, see Box 3.

Box 3 – Voluntary restriction of practice

Dear [Practitioner]

I am writing to confirm your undertaking today that with immediate effect and until further notice you will not provide any form of care to [specified patients], either at [normal workplace address] or at any other workplace.

You accepted that this is a formal undertaking and that if you breach the undertaking it would constitute professional misconduct and it would be appropriate for [organisation] to refer the breach to [professional regulator].

You will now have had opportunity to discuss this undertaking with your [defence society]. If you are still in agreement please confirm this by sending me the enclosed copy of this letter, signed and dated. If we do not receive this by [date] we will take formal action to protect patients.

Your undertaking will remain in force until our current investigation is complete. We will review it as part of the process of deciding the action to be taken (if any) in the light of the investigation's findings.

Yours sincerely

[Manager]

In situations such as this, the organisation may also need to consider whether to inform the relevant professional regulator. Regulators are concerned with issues that raise questions about a practitioner's fitness to practise. In its initial consideration of a case the healthcare organisation has a number of options, including referral to the regulator and other agencies. If it has been decided that a local performance investigation alone is required and, providing patient safety is assured, then there will be no reason to notify the regulator unless or until local proceedings identify serious concerns which bring into question the practitioner's capacity to practise at all. If in doubt, discuss the options with NCAS.

Where a practitioner giving cause for concern has resigned or been dismissed by the employer or is otherwise unavailable, the organisation may still decide to carry out an investigation to learn from the episode and, if possible, prevent it happening again. Where a practitioner moves away before performance concerns have been resolved, and is thought to pose a significant risk if re-employed elsewhere, organisations can also consider the issue of an alert notice. See www.ncas.npsa.nhs.uk/toolkit/disciplining/consider-who-else-needs-to-know for more advice on use of alert notices. Once issued, alert notices must be kept under review and rescinded as soon as they cease to be applicable. Alert notices are not issued in Scotland.

2.2 Protect people raising concerns

Whistleblowers and other people raising concerns about professional colleagues may feel vulnerable, particularly if still working with the practitioner concerned. As long as their concern is genuine, they should be protected by the organisation's local policy on whistleblowing and, where applicable, the *Public Interest Disclosure Act 1998* (PIDA). The organisation's human resources team could offer advice on the Act's provisions. Advice for individuals could also come from local representative committees, union or defence society advisers, or from professional regulators. The charity, Public Concern at Work (www.pcaw.co.uk) also offers confidential advice which can be accessed by people not employed by the organisation and therefore not covered by PIDA.

In practice, it is not usually possible to protect the identity of reporting practitioners, especially within small teams. Practitioners with potential performance concerns are likely to ask questions and try to guess the name of informant(s). They may make counter-allegations which will put working relationships under strain. Explaining the situation and the organisation's investigative procedures to both parties can help formalise the position and

prevent discussion within the team. Remind the practitioner and others involved in the investigation to avoid any action which could be seen as attempting to influence witnesses or influence the investigation in other ways.

Managers should recognise the stress that the practitioner may be under. At the same time, they must try to protect those around from further stress. If it becomes difficult for a team to continue functioning effectively then suspension or exclusion from work may have to be used, either against the practitioner whose performance is a concern or against another practitioner who is not treating the investigated practitioner reasonably.

Where witnesses ask to provide information anonymously, the investigator needs to strike a balance between the rights of the practitioner under investigation and the need to collect evidence. There are some circumstances where it may be possible to proceed even if the practitioner is not informed of the identity of witnesses. The important need is for the practitioner to know the evidence against them and the case they have to answer.

The courts have held anonymity to be reasonable in cases involving sexual misconduct or where there is a real or perceived risk of harm to the informant. In these circumstances the investigator should take a full statement from the witness and then anonymise it by erasing the parts which could identify the witness.

In other cases the investigator should explain why anonymous allegations are undesirable. So long as the concerns are genuine, the informant ought to be protected by any local policy on whistleblowing and, where applicable, by the provisions of PIDA.

When anonymous information is taken into account it is good practice for the investigator to record the issues considered and the reasons for allowing the informant to remain anonymous. The investigator should be available at any subsequent hearing to be cross-examined on the anonymous evidence and the reasons for anonymity.

2.3 Keep patients informed

Patients who are already aware of a concern (as complainants, for example) should normally receive the information provided for by the organisation's complaints handling procedure about the actions being taken and relevant timescales. Depending on the circumstances, it may be appropriate to brief patients more actively.

It would not be usual to release information about an ongoing investigation more widely to patients, unless some form of public announcement is necessary – in the event of a look-back exercise, for example. It would then be good practice to discuss a proposed information release with the practitioner first.

Information about a look-back will depend on the facts of the case. Whether a look-back exercise is necessary should be discussed with appropriate experts, for example in the relevant royal college or the Health Protection Agency. Patients whose care has to be reviewed should be contacted with an explanation of the medical need for the review and its implications. A contact point should be identified for further information. Where possible, a review exercise should not identify the practitioner concerned.

Media enquiries will usually go to named individuals within the organisation who have been trained and authorised to respond to them. The information provided to the media should not differ from the information which might have been given to individual patients. Care must be taken to preserve the confidentiality of patients and, where possible, the confidentiality of the practitioner.

The organisation will probably have local policies on media handling and on access to internal communications advice. Depending on the sensitivity of the issues, it could be appropriate to take external advice as well, to ensure that any information about the investigation reaches the media in the most appropriate way. Where possible, any information to be given to the media should be discussed with the practitioner in advance and the practitioner should have an opportunity to discuss the proposed statement with a union or defence society representative.

2.4 Support the practitioner

The practitioner was probably already told that an investigation might take place (see section 1.3). Once the decision to investigate has been taken, there should normally be another meeting, organised in the same way, with the practitioner offered the opportunity to be accompanied, and with a note of the meeting kept.

The meeting can, as appropriate, explain and allow questions about:

- Terms of reference, timescale, names of case manager(s) and investigator(s) and the process which the practitioner can use to respond to the concerns raised.
- The regulations and local procedures governing the case's handling. In England, for example, MHPS contains detailed guidance on investigation procedures while the Performers List Regulations do not specify how investigations should be conducted. The organisation therefore needs to be clear to the practitioner about which procedures it is applying.
- The reasons for any restrictions on practice or suspension/exclusion, with explanation of the potential consequences if requirements are not complied with. The relevant regulations set out notification requirements – see www.ncas.npsa.nhs.uk/mustknows
- Any proposed statements to patients, colleagues or the media, with the practitioner given enough time to discuss them with advisers/representatives. Ordinarily, colleagues would not have a direct need to know why the practitioner is under investigation or why they have been suspended or excluded from work. But some limited release of information may be appropriate and it is better if this can be agreed with the practitioner.
- The need for the practitioner not to attempt to influence potential witnesses – the same instruction going to everyone else involved in the investigation.
- Personal support mechanisms.

Being the subject of an investigation is likely to be very stressful for the practitioner. Support mechanisms could include access to occupational health services and professional psychological support or counselling. Managers should use occupational health services for advice on fitness to work or related questions about the practitioner's health. When making a referral to an occupational health physician, be explicit about the health issues which are causing concern. Use of GP or other routes does not prevent the occupational health physician giving advice on fitness for work, if necessary, provided there was a manager referral in the first place. If the practitioner self-refers to the occupational health service, the manager will not necessarily receive feedback.

Remember, when conducting an investigation, that it is likely the practitioner will continue working for the organisation afterwards so it is important to try to maintain an effective relationship throughout the process.

2.5 Protect the organisation

Keep in mind what could happen next and the need not to put investigators and decision-makers in positions where they might appear later not to be acting impartially, putting the organisation's actions at risk of challenge:

- People who might be involved in subsequent disciplinary proceedings or appeals should not be part of a decision to investigate or an investigation.
- People carrying out investigations should not be involved in later decisions to take formal action against a practitioner based on the investigation's findings.
- The position of the chief executive (CEO) should not be compromised. The responsible manager will need to report a serious concern to the CEO as the accountable officer, as soon as it is known about. But if local procedures mean that the CEO is likely to participate in subsequent formal decision-making processes (such as consideration of list removal or exclusion/suspension), the CEO should only be told the broad nature of the concerns.
- Sometimes a practitioner whose performance is causing concern may complain of bullying or harassment. Such complaints should be investigated in accordance with local policies, but overseen by a manager who is not otherwise involved in handling the concern.

3. Managing the investigation

The investigation starts once its terms of reference are finalised and when a case manager and investigator(s) have been appointed. Once the decision is taken to hold an investigation there should normally be discussion with the practitioner to secure as much engagement as possible. The practitioner should be made aware of the terms of reference and who the proposed case manager and investigator(s) are so that any objections can be raised.

The organisation can then:

- finalise terms of reference;
- appoint a case manager;
- appoint case investigator(s).

The investigator(s) will:

- collect evidence;
- interview the practitioner;
- weigh the evidence and identify the facts of the case.

3.1 Finalise terms of reference

These will have been agreed in outline at the time a decision was made to carry out the investigation, but some final drafting may be needed. The terms of reference as finally drafted should be agreed by the organisation's relevant decision-maker(s). The case manager and investigator(s) appointed to manage and carry out the investigation (see next sections) would not normally be involved in this process.

Terms of reference should be tight enough to prevent an unfocused general investigation of everything concerning the practitioner. It may be appropriate to specify areas not to be investigated as well as the areas where evidence and commentary are expected. Box 4 suggests a format.

Box 4 – Terms of reference for an investigation

An investigation is commissioned into the performance of [practitioner's name], working as a [practitioner's job title] for [organisation's name], at [workplace address].

The matters to be investigated are [].

The following matters are excluded from the investigation [].

It is expected that the investigation will be completed by [date] and that a report will be submitted to [named manager] by [date].

The report should detail the investigation's findings of fact and include a commentary on how the performance of [practitioner's name] compares with that expected from a practitioner working in similar circumstances.

As a minimum, terms of reference should set out:

- the issues to be investigated;
- the period under investigation;
- the timescale for completion.

It may be that as the investigation progresses the terms of reference are found to be too narrow or that new issues emerge that warrant further investigation. In such cases, the investigator(s) should inform the case manager who should seek the agreement of the responsible manager or DMG to a widening of the terms. Such requests should be decided on promptly so that the investigation is not delayed. The practitioner must be informed of any changes to the terms of reference unless, exceptionally, he is kept unaware of the investigation at all.

3.2 Appoint a case manager

A case manager is normally appointed by the DMG (in primary care) or the responsible manager (in the H&C sector). Usual practice is for a case manager to be a senior member of the organisation's staff, with a role to:

- ensure that the investigation is conducted efficiently;
- ensure that confidentiality is maintained where appropriate;
- act as the coordinator between investigators, the practitioner and anyone who the investigators need to interview;
- obtain any documentation required;
- ensure that the process is properly documented;
- receive the investigator's report;
- make recommendations to the responsible manager or the DMG on what action might follow, having regard to the contents of the investigator's report.

To be seen to be objective, case managers need to be able to demonstrate that they:

- understand the general nature of the concerns raised and the clinical and work contexts in which they occurred;
- are sufficiently senior within the organisation to secure the cooperation of other staff members;
- are familiar with the local policy for investigating concerns and related procedures;
- have, preferably, some training and experience in undertaking performance investigations;
- have access to relevant advice and expertise from colleagues within the organisation;
- have access to relevant external experts and authority to instruct them;
- have the necessary protected time to support the investigation.

The case manager should have no real or perceived conflict of interest in relation to any aspect of the investigation. Given the structure of the NHS and the small size of some organisations, minor conflicts of interest are difficult to avoid. Any reservations about the choice of a case manager ought to be reported to the DMG or responsible officer at the outset so that a decision can be made about their significance. The practitioner's views should also be taken into account.

In England, MHPS requires that the medical director should act as case manager for cases involving clinical directors and consultants.

3.3 Appoint case investigator(s)

Normal practice is for the investigative work to be carried out by a second senior staff member, or possibly more than one. An investigator's role is to collect and examine relevant evidence and complete the investigation in line with its terms of reference. The investigator will ask the practitioner for a response to the concerns raised, resolve any conflicts of evidence, determine the facts and produce a report which accurately captures all relevant details and findings. All investigators also have a duty to maintain confidentiality and ensure that the investigation is documented.

Usually investigators can be identified within the organisation but occasionally it is necessary to commission an external expert where a suitable person is not available internally. All investigators must be asked to confirm at the outset that there are no real or perceived conflicts of interest disqualifying them from doing the work in question. As for case managers, it may not be possible to identify an investigator totally without knowledge of the practitioner in some administrative capacity. As for case managers, any doubts about impartiality should be raised at the outset.

When asked to undertake an investigation, investigators should be able to demonstrate that they:

- have the necessary expertise to conduct the investigation. In the event that the nominated investigator does not have a relevant clinical background they should ensure that they obtain appropriate advice where issues of clinical judgement are raised. If there are no other senior clinicians with the relevant expertise, a senior clinician from another NHS body should be involved;
- understand the work context of the practitioner;
- have time to complete the investigation and report in a reasonable timescale.

Where more than one investigator is instructed, a lead investigator should be nominated to lead the investigation, ensure compliance with the terms of reference and complete the report.

3.4 Collect evidence

Evidence needs to stand up before an impartial tribunal. It includes written materials such as patients' clinical records and other organisation records, appraisals or other information held on the practitioner's personal file which is relevant to the investigation, as well as oral and written evidence provided by witnesses to specific events and any other relevant factual information. The practitioner is also a witness.

An investigation will often begin with a planning meeting between the case manager and investigator(s) to determine, for example:

- what documents need to be seen;
- who will be interviewed;
- how to manage administration of the investigation;
- means of communication with the practitioner;
- other logistical issues.

The investigating team will need to take a view on whether patient records need to be accessed to assist the investigation. Normally this will require prior patient consent but in certain circumstances there can be a public interest justification for disclosure without consent. It may be necessary to take advice from the organisation's Caldicott Guardian in the first instance, and possibly also from the organisation's legal advisers.

Once collected, evidence must be stored safely. Attempts to alter evidence can be prevented if original documents are obtained as soon as possible, and kept securely. Where it is necessary to give the practitioner access to documents, they should be provided as copies or viewed under supervision.

For guidance on conduct of interviews, including use of the PEACE model (Preparation and planning, Engage and explain, Account, Closure and Evaluation) go to: www.ncas.npsa.nhs.uk/toolkit/investigating/train-investigators/resources

The investigator should remain objective and avoid leading the witness through inappropriate feedback or comment. At the end of the interview the witness should be asked if there is anything else that they wish to add to the evidence that they have given. Following the interview, witnesses should be given a comprehensive note and asked to confirm that it is an accurate record of their interview. Alternatively, it is open to the healthcare organisation to commission its legal advisers to obtain a formal witness statement.

In general, there is no need for witnesses to be accompanied. If a witness requests a friend or supporter to be present, the investigators may allow this but the friend should take no part in the interview and should not answer questions or make statements on the witness's behalf.

Accurate records should be kept of all interviews. Interviewees may feel inhibited by the use of recording equipment. If recording is proposed, do not turn the equipment on until the interviewee has agreed to its use. Explain why you would prefer to use it, who will be entitled to listen to it and how long the recording will be retained before being erased. If the witness does not agree, have a note taken by a second person, so that the investigator can concentrate on asking questions.

See Box 5 for an example of how a witness statement might be set out. There are several ways of putting witness statements into writing. It may be appropriate for some witnesses to write their own statements. But it is also acceptable for the investigator to question, take notes and then draft the witness statement, using the witness's own words so far as possible. The witness can then check the draft, ask for alterations to be made, if necessary, and sign the statement as an accurate record.

Box 5 – A witness statement format

Investigation reference number

Statement made by [witness] to [investigator] after interview on [date].

This statement was drafted on my behalf by [investigator] and I have confirmed its accuracy, having seen it in draft and having been given an opportunity to make corrections or additions.

The investigator told me the terms of reference of the investigation and asked me questions about [].

The investigator also showed me [] and asked me to comment on [] attached [] to this statement.

I said [facts of the case as known to the witness, in chronological order].

I said that [] also [observed the event in question] and could corroborate this statement.

I believe that the facts in this statement are true.

Signed

Date

3.5 Interview the practitioner

Precisely what information will be given to a practitioner under investigation will depend on the circumstances of the case and on any relevant rules, regulations and procedures governing its handling. The investigator must be free to collect evidence without being pressurised by the practitioner or the practitioner's representative.

Assuming it is appropriate for the practitioner to know that the investigation is taking place (that is, no advice against telling the practitioner has been given by the police or a fraud agency), the practitioner should be invited to provide any information thought relevant to the matters under investigation. This might include documentary evidence as well as identifying witnesses, and providing oral evidence. The investigator(s) should take account of

any evidence provided by the practitioner which is consistent with the investigation's terms of reference. It may be appropriate for the practitioner to be interviewed twice, at the start of the investigation (see also 1.3) and at the end when all other evidence has been collected. The first interview gives the practitioner an opportunity to comment on the investigation process while the second allows the practitioner to be questioned about information likely to be used in the investigation report.

Prior to being interviewed the practitioner might request sight of the evidence on which the investigator(s) propose to rely in their report. This would normally be permitted, once the evidence has been collated into its final form. England's MHPS says that the practitioner must be shown a copy of the investigator's report in capability cases but this is not a requirement in MHPS conduct cases. Local procedures will need to be clear as to what, if any, access the practitioner will be given to the investigator's report to correct any matters of factual error before its submission to the case manager for consideration.

The *Employment Relations Act 1999* gives employed practitioners the right to be accompanied by a union/professional body representative or by a work colleague. While that person might speak on behalf of the practitioner, the practitioner must answer any specific questions put to them about their own actions. Many organisations also allow a friend, partner or spouse to provide support to the individual in a similar manner. In England, where MHPS has been adopted, employed practitioners have an additional right to a legally qualified representative.

For practitioners whose cases are being investigated under Performers List Regulations, there are no statutory provisions on how an investigation should be conducted but it is good practice, where possible, to give such practitioners the same opportunities to be supported as employees.

A practitioner cannot be compelled to attend an investigation interview or answer questions but, in general, the only justification for declining to answer questions is that to do so would be incriminating. Failure to attend an interview or cooperate may in itself warrant further action. Professional regulators expect practitioners to cooperate and contribute to local inquiries to help reduce risk to patients, so regulator referral may be an option for the organisation where non-cooperation arises.

Not answering questions denies the practitioner the opportunity to ensure that their own account of events is properly presented to the investigators. The practitioner's own account of events might still be presented at any later hearing that might arise.

3.6 Weigh the evidence and identify the facts of the case

Having collected the evidence, the investigator(s) should set out the facts as they see them, weighing the evidence on the balance of probabilities and taking as true anything which appears more probable than improbable. The more serious the concerns about the practitioner, the greater the need for the investigators to satisfy themselves that the evidence supports their findings of fact.

Investigators will need to take positions on:

- **Written versus oral evidence:** while written evidence may be more clearly defined, oral evidence can be tested by questioning and could be taken as equally reliable, depending on the circumstances. Written witness statements are best compiled in the words of the witness and signed and dated. Both forms of evidence are best collected as soon as possible after the events in question.
- **Age of evidence:** apart from determining what is meant by 'old' in local proceedings, it might be considered that a pattern of unacceptable performance (including conduct) over a period of time is likely to be more significant evidence than an isolated incident even if occurring recently.
- **Seeing the event itself or seeing the aftermath:** factual evidence ought to carry most weight. Opinions of witnesses and unsupported anecdotal evidence are likely to have limited use.
- **Technical competence:** where the investigator identifies a need for specialist advice to interpret a technical issue outside their expertise, the case manager should make arrangements for it to be provided so that evidence is appropriately interpreted.

- **Evidence from previous investigations:** all relevant evidence should be considered, including previous complaints and investigations where relevant, provided there are adequate records of the events and actions that were taken at that time, or matters were of a serious nature such that they continue to have a relevance to the matters now under investigation and can usefully form part of the investigators' report.

In order to be able to demonstrate a fair process, if there is any uncertainty about how to treat a specific piece of evidence, advice should be sought from the healthcare organisation's legal adviser.

Some conflicts of evidence are probably inevitable as individuals present different accounts of the same events. Not all conflicts of evidence need to be resolved, only those that affect the investigators' findings of fact about the performance concerns being investigated.

Normally, independent accounts which corroborate each other are likely to be preferred to disparate accounts of the same incident, or similar accounts provided by people known to be antipathetic to the practitioner under investigation. In drafting their report, investigators should record material conflicts of evidence stating which version of events they preferred and why.

3.7 Manage the timetable

MHPS states that the case investigator should aim to complete the investigation within four weeks of appointment and submit a report to the case manager within a further five days. In more complex cases it may not be possible to do this. But it is good practice to try to complete investigations within a reasonable timescale taking into account the circumstances of the individual case. Delays are damaging to the healthcare organisation, the practitioner, and to other staff and patients. The investigation process can lose momentum and become stale. Active management of the process by the case manager is essential if delays are to be avoided.

Where key individuals are difficult to contact and interview, all reasonable steps should be taken to accommodate their other commitments. Case managers should receive the full support of senior management in overcoming any delays.

Practitioners who are unavailable should be given a reasonable opportunity to participate in the process, which may involve close liaison with their representative. The representative will be aware that failure to cooperate means that the practitioner's oral or written account of events may not be received by the investigators in time to influence the report.

Where a practitioner's current health status is preventing their participation in the investigation process, an occupational health assessment might be offered to ascertain whether, whilst they may not be fit to return to work, they are well enough to be interviewed.

All this adds up to a checklist for monitoring the investigation's progress, once started – see Box 6 (page 18).

Box 6 – Investigation checklist

	Responsibility	Date
Decision to investigate made	Decision-makers	
Practice restriction/suspension/exclusion considered	Decision-makers	
Case manager appointed	Decision-makers	
Investigator(s) appointed	Decision-makers	
Timetable finalised	Decision-makers	
Terms of reference finalised	Decision-makers	
Practitioner notified of decision to investigate	Case manager	
Practitioner notified of investigator arrangements	Case manager	
Meeting with practitioner to discuss arrangements	Case manager	
CEO told of arrangements made	Case manager	
Communication channels established (phone numbers etc)	Case manager	
Document requirements identified	Investigator	
Document storage system set up	Case manager	
Documents provided to investigator	Case manager	
Interviews identified	Investigator	
All interviews timetabled (including practitioner's)	Investigator	
First interview with practitioner completed (on process)	Investigator	
Note of first interview agreed	Investigator	
Interviews with other witnesses completed	Investigator	
Other witness notes agreed	Investigator	
Second interview with practitioner completed (on case)	Investigator	
Note of second interview agreed	Investigator	
Report in first draft for discussion with case manager	Investigator	
Report in second draft for accuracy check	Investigator	
Submission of report	Investigator	

4. Reporting

The final step is for the investigator to write a report – if possible within the five days suggested by MHPS. Like the rest of the investigation this will require dedicated time. The task will be easier if the case manager has organised a tight filing system to support the investigation. Consider the following:

- **documentation systems;**
 - **the report;**
 - **circulation;**
 - **next steps.**
-

4.1 Documentation systems

At the end of the investigation the organisation ought to have a comprehensive record of the information gathered during the investigation, with transcripts and witness statements where applicable. It is the case manager's responsibility to ensure that the investigation is documented and that all information held is identified and retrievable.

Case records should be kept securely and remain confidential. Electronic and hard copy records are equally acceptable. They should be handled in accordance with local and national data management requirements set out in the *Data Protection Act 1998* and the *NHS Code of Practice on Confidentiality* (Department of Health 2003). There is no nationally-set rule on retention periods for investigation records so organisations will need to determine their own retention periods for case documentation, taking into consideration local policies on, for example, retention of employment records.

During an investigation the practitioner may request access to relevant case papers, such as original clinical records which may form the basis of any questions to be posed by the investigator. It would be normal for such requests to be met.

4.2 The report

The key document is the investigator's report. This should be a self-contained document with enough information within it to inform a subsequent decision on whether concerns are unfounded or confirmed, whether or not further action is needed and, if so, the type of action to be taken.

The decisions would be made by a decision-making group of some description (in primary care) or (elsewhere) by the responsible manager in consultation with relevant senior colleagues and on the advice of the case manager. In primary care, available actions would be as provided for in performers list regulations. Elsewhere, action would either be under capability or conduct procedures, and the investigation would need to discuss the relevance of each of these procedures.

Wherever possible the report should exclude reference to identifiable individuals other than the practitioner. A suggested structure for an investigation report is shown in Box 7 (page 20). It will not be appropriate for every investigation but it shows how evidence can be set out in order to be as clear as possible and inform the decision-making process effectively.

Box 7 – A report template**Front cover**

Strictly confidential

Organisation name

Report of investigation into concerns raised in relation to [practitioner's name and address]

Organisation's case reference number

Date

Contents page

Chapter headings with page numbers. Headings might include: Introduction, Background, The investigation, Methods, Findings of fact, Summary of conclusions.

The report can refer to annexes as necessary. Each document referred to should have a unique identifier. Where there are many documents it is helpful to categorise them by type – witness statement, clinical record, summary of witness interview, etc. The system will follow from the filing system set up at the start of the investigation.

Report

The report needs to set out the case story. The sections which will be appropriate will depend on the nature of each case but the following elements will normally need to be included somewhere:

- **Introduction:** brief introduction to the investigation, its relationship with any investigations by other bodies and the procedures and regulations governing the present investigation.
- **Background:** relevant career information about the practitioner and work with the organisation, with reasons for the investigation in more detail.
- **The investigation:** the specific allegations for investigation, the team carrying out the investigation (with names, job titles and qualifications), the terms of reference as set initially plus any subsequent amendments.
- **Methods:** for example, review of patient records, audit of a specific set of cases, prescribing reviews, interviews with specified patients and/or colleagues. If any expert witnesses were used, their expert credentials should be reported. There should be a list of all people interviewed and the capacity in which they were involved in the investigation.
- **Fact-finding:** what has happened, set out in chronological order and with supporting evidence identified. Where the fact-finding include the opinion of case investigators or other experts on a standard of care, the required standards of care should be quoted. The findings should draw attention to any conflicts of evidence and whether it was necessary to resolve the conflicts in order to complete the investigation. Grounds should be given for preferring one version of events to another.
- **Conclusions:** the conclusions reached on each of the points listed in the terms of reference, cross-referenced to the findings of fact.

Signed [Investigator(s)]

Date

4.3 Circulation

Circulation of the investigator's report is normally limited to the practitioner, case manager, members of the DMG (in primary care) or the responsible manager (elsewhere). In addition, and once appointed, a copy should also go to the responsible officer in England, Wales and Scotland. The DMG or the responsible manager may, at their discretion, consider whether it would be reasonable for the report subsequently to be seen by others.

The report should remain confidential. Where disclosure to any other person or body is deemed appropriate, disclosure should be kept to the necessary minimum and limited to specified individuals or bodies who are themselves under a duty of confidentiality about the information.

4.4 Next steps

At the conclusion of the investigation it is for the DMG or the responsible manager to determine what further action, if any, is required. There are many potential options, ranging from taking no further action or arranging local counselling and mentoring, to referral to the regulator or use of local disciplinary or capability procedures.

Once a decision has been reached the case manager should arrange to meet the practitioner to explain the outcome of the investigation. It remains open to the healthcare organisation to contact NCAS for further advice at any stage.

Glossary

Alert notice

Alert notices are used where a practitioner is believed to pose a serious potential or actual risk to patients or staff and who is believed likely to be working or seeking work elsewhere in a health or social care setting. See www.ncas.npsa.nhs.uk/toolkit/disciplining/consider-who-else-needs-to-know for advice on use of alert notices.

Area Professional Committees

In Scotland, Area Professional Committees are the statutory representative bodies for local practitioners. They are the equivalent of local representative committees in England, Wales and Northern Ireland.

Balance of probabilities

The balance of probabilities is the standard of proof required in most civil proceedings. It is met if allegations appear more likely to be true than not true.

Case investigator

A case investigator examines the relevant evidence in line with an investigation's terms of reference, determining findings of fact and producing a report.

Case manager

A case manager coordinates the investigation, organises its administrative support and tries to ensure that the investigation is completed to a timetable.

Clinical records

Clinical records include any information relating to the care or treatment of any current or former patient, including notes made by clinical staff, correspondence between clinicians, clinical photographs, video and audio recording, pathology results.

Confidentiality

Confidentiality is a legal obligation as well as a requirement of professional codes of conduct. It is also a specific requirement within NHS employment contracts and breaching confidentiality can lead to disciplinary action.

Counter fraud agencies

The NHS Counter Fraud and Security Management Service in England and Wales, and equivalent bodies in Northern Ireland and Scotland.

Decision-making group (DMG)

While procedures in primary care organisations vary, there will usually be a two-tier structure, with a performance advisory group (PAG) and a decision-making group (DMG). See NCAS guidance, *Handling performance concerns in primary care* (2010).

Defence societies

Amongst a range of member services, defence societies advise practitioners whose performance has caused concern.

Duty of cooperation

Practitioners have a professional and usually also a contractual responsibility to cooperate with investigations into standards of care and related issues. Only if cooperation could lead to incrimination are practitioners entitled to decline to answer questions.

Evidence

Evidence is the totality of the information relevant to the investigation to establish the facts about events. Evidence will come from a variety of sources and may be written or oral and in paper or electronic format.