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
1 Nine Elms Lane
London
SW8 5NQ

T 020 7062 1620 (General Switchboard)
F 020 7084 3851

Ref: 0901 January 2010

Toal, Vivienne

From: Hynds, Siobhan <Personal Information redacted by the USI>
Sent: 21 February 2017 10:16
To: Murphy, Annette
Cc: Toal, Vivienne; Parks, Zoe; Hainey, Lynne
Subject: Review of MHPS

Importance: High

Annette

Could you please get a date for a meeting with Vivienne, Zoe, Lynne and myself to meet to review recent MHPS cases and to review our Trust Guidance. Can you try to get a date sometime in March, for approx. 2 hrs in CAH.

Thanks

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: Personal Information redacted by the USI Mobile: Personal Information redacted by the USI Fax: Personal Information redacted by the USI

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Toal, Vivienne

From: Murphy, Annette <[redacted]>
Sent: 22 February 2017 12:33
To: Hynds, Siobhan; Toal, Vivienne; Parks, Zoe; Hainey, Lynne; Walker, Helen
Cc: McNeice, Andrea; Mallagh-Cassells, Heather
Subject: RE: Review of MHPS

Hi All,

Please see below confirmation of meeting to: **Review recent MHPS Cases and to review Trust Guidance**:

Date: Thursday 2nd March 2017
Time: 10.00am to 12.00 Noon
Venue: Seminar Room 1, Medical Education Centre, Craigavon Area Hospital

If you have any queries please get back to me.

Regards

Annette

Annette Murphy
HR Assistant
Employee Relations
Hill Building
St Lukes Hospital Site
Loughgall Road
Armagh
BT61 7NQ

From: Hynds, Siobhan
Sent: 21 February 2017 11:47
To: Murphy, Annette
Cc: Toal, Vivienne; Parks, Zoe; Hainey, Lynne; Walker, Helen
Subject: RE: Review of MHPS

Annette

Sorry – I missed Helen off the list – can you please include her.

Thanks

Siobhan

From: Hynds, Siobhan
Sent: 21 February 2017 10:16
To: Murphy, Annette
Cc: Toal, Vivienne ([redacted]); Parks, Zoe ([redacted]); Hainey, Lynne ([redacted])
Subject: Review of MHPS
Importance: High

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Siobhan

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Toal, Vivienne

From: Parks, Zoe <Personal Information redacted by the USI>
Sent: 05 April 2017 15:43
To: Toal, Vivienne; Walker, Helen; Hynds, Siobhan
Subject: Draft Guidance as discussed re Handling Concerns Medical Staff
Attachments: 5.4.17 DRAFT - SHSCT - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS).doc; 1 SHSCT - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 23 September 2010 (2).pdf

Importance: High

Dear all,

As previously discussed, I have prepared a DRAFT new version of the Trusts guidelines for handling concerns about Doctors/Dentists performance for your comments. This revised version provides more guidance around the early part in managing concerns - as it would appear from experience this is where we sometimes come unstuck. I have also removed the Oversight Committee from the process.

I have included our previous guidance just for your reference as I haven't used tracked changes. Happy to discuss

Zoe

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

Follow the SHSCT:

Click here for the Medical Staffing **Sharepoint site**

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 is concern in identified, it should go through a screening process to identify whether an investigation in 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[1] 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 expediously 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

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development
- Appropriate Operational Director

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Formal Investigation
- Exclusion / Restriction

** 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

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding compliance.

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

Appendix 2

Formal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the formal process.

Chief Executive, following discussions with the MD and HROD, appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator must complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Appendix 3

Conduct Hearings / Disciplinary Procedures

Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Oversight Group
- Practitioner

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

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 Practitioners 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

During the hearing:

- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:

- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:

- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:

1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

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).

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

If the decision is to exclude the Practitioner:

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive and Oversight Group. (Refer to MHPS Section II point 28 for review process.

Appendix 6

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

Updated March 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 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. 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.

1.5 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.

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 the 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:

- 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
- 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 Working Well Together and Harassment at Work procedure, 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 appropriately – this in itself can also represent a concern, which would necessitate intervention.

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 doctors 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) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation in 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.

3.0 SCREENING PROCESS

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 Staffing 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 formal meetings as this would be part of any subsequent investigation process if needed. You will also need to inform the individual who the received complaint is against, 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. The purpose of this stage is to gather enough information to enable the Clinical Manager, supported by a senior HR Manager (e.g. Medical Staffing 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.

3.1.3 It is important that the process is transparent. Early communication about the performance causing concern can contain in some cases reasonable explanations for concerns and early interventions to better performance can be found. The practitioner's early response can be helpful in deciding whether to carry out an investigation.

3.1.4 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 advice early meetings or early disclosure could compromise subsequent investigations.

3.1.5 In situations where a person's ill health is 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 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 a Terms of Reference established and agreed by Medical Director/Case Manager
The individual concerned has been made aware informally that there is an issue.	Individual would have been notified formally by Med Director /case manager to inform of the formal proceedings that will take place
Issue is known 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 no right to rep	Right to notice to prepare following formal invite to a meeting in writing
No right of representation	Right of representation applies
Progress is being managed locally with HR	Progress is being monitored by a nominated

support	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. It may also be worthwhile reminding individuals that support is also available to them through their trade union representative.

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, it is likely this decision will be taken in consultation with the Medical Director and Director of HR. 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 minor shortcomings are isolated

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. 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. 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.

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 future performance and 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 Staffing Manager. This is not a formal disciplinary sanction.

3.4.3 Action in the event that serious shortcomings are identified or previous informal action has not resulted in the required change.

When 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 place temporary restrictions on a practitioner's practice. The Medical Staffing Manager must also be informed 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)

An 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. In these situations, a well undertaken investigation and report will help to clarify any action needed. The decision following the initial screening, can therefore result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

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 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.

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 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

Appendix 1

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs

Early in process
- Practitioner

For information only at this stage
- Chief Executive
- Medical Director
- Director of Human Resources

↓

Clinical Manager and Senior HR Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

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Clinical Manager and senior HR Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and senior HR Manager assess what action should be taken following initial screening process – in consultation with MD/Dir HR

→ No Action Necessary, Reason documented and held on file

→ Informal remedial action with assistance from NCAS, if appropriate: Local action plan and/or informal warning issued.

→ Matter escalated to Medical Director / AMD for consideration of immediate exclusion / restriction on duties.

→ Matter escalated to Medical Director / AMD to initiate a Formal Investigation and ensure a Terms of Reference are agreed.

** 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

Informal Remedial Action

A determination by the Clinical Manager and senior HR Manager is made to deal with the issues of concern through informal remedial action

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors compliance with agreed plan.

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

Appendix 2

Formal Process

A determination by the Clinical Manager and senior HR Manager is made to deal with the issues of concern through the formal process.

Medical Director (following discussions with Chief Executive, and HROD), appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator should, other than in exceptional circumstances complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Appendix 3

Outcome of Formal Investigation:
Conduct Hearings / Disciplinary Procedures

Following the formal investigation, the Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Practitioner

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal action, the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and Security Management Service must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief Professional Officer at the DHSSPS or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 3a

Outcome of Formal Investigation:
Clinical Performance Hearings

Following the formal investigation, the 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
- 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 Practitioners 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.

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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.

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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

During the hearing:
- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:
- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:
- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:
1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

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.
- 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 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.

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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.

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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

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II point 15 to 21 for details.

Appendix 6

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 supervising Consultant, 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 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 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

Updated March 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 ~~Maintaining High Professional Standards~~ (MHPS)) was issued by the then 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 of practice or suspension (known in MHPS as exclusion).

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~~ must have in place procedures for handling concerns about an individual's performance which reflect the framework. 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~~ 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.

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.

Commented [JT1]: Generally, I would suggest that direct quotations from MHPS or from the NCAS guidance should be clearly identified as such. Internal Trust processes or guidance should be distinguished from MHPS requirements in particular as the latter have a particular status and must be complied with.

Commented [JT2]: I think we need to make it clear that MHPS is binding and must be complied with. It therefore takes precedence over either the NCAS guidance or this guidance.

Commented [JT3]: This is a direct quote from MHPS

Commented [JT4]: In fact there is very little if any reference in this guidance to the role of the RO??

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 ~~the~~ 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:

- 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

Commented [JT5]: This is also a direct quote from MHPS

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 Working Well Together and Harassment at Work procedure, harassment can represent a single, serious incident or persistent abuse.

Commented [JT6]: Do you want to say anything else here about handling cases involving allegations of harassment and/or bullying etc?

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 ~~would~~ 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 in 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

Commented [JT7]: I think the checklist at page 7 of the NCAS guide is particularly useful and could perhaps be referred to here?

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 Staffing 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**.

Commented [JT8]: Is this screening intended to fulfil the requirement for preliminary establishing of facts under MHPS?

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. You will also need to inform the practitioner who is the subject of the

concernindividual who the received complaint is againstt, 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.

3.1.23.1.3 The purpose of this stage is to gather enough information to enable the Clinical Manager, supported by a senior HR Manager (e.g. Medical Staffing 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.

3.1.33.1.4 It is important that the process is transparent.

can be found. The practitioner's early response can be helpful in deciding whether to carry out an investigation.

3.1.43.1.5 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 advisee early meetings or early disclosure could compromise subsequent investigations.

3.1.53.1.6 In situations where a personpractitioner's ill health is 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 Iinvestigator – trained in MHPS and equality has been appointed by the Cease Mmanager - this would not ordinarily be the supervising consultant.
Information readily available is gathered quickly, surrounding the concern/complaint	Investigation is directed by a Terms of Reference established and agreed by Medical Director/Case Manager
The individual concerned has been made aware informally that there is an issue.	Individual would have been notified formally by Med Director /case manager to inform of the formal proceedings that will take placethat a formal investigation under MHPS is being commenced

Commented [JT9]: The NCAS guide goes a bit further than this and says "There will normally need to be **input** from the practitioner too". I agree with this. at the very least, preliminary comments should be sought from the practitioner and I would advise, in line with para 30 of section 1 of MHPS, that they should be afforded the right to be accompanied.

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Commented [JT10]: This sentence is a little clumsy. Can the point be clarified?

Commented [JT11]: See comment 9 above.

Commented [JT12]: In such cases there should be close liaison with CFPS and/or the PSNI.

Commented [JT13]: This is a requirement under MHPS

Commented [JT14]: This is a bit vague. Adopt the wording of the NCAS Guide

Issue is known 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 no right to rep	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

Commented [JT15]: Not sure what this means? Resolved locally??

Commented [JT16]: But see comment 9 above

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. ~~It may also be worthwhile reminding individuals~~ 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, it is likely this decision will be taken in consultation with the Medical Director, Director of HR and operational Director. Possible action could include:

Commented [JT17]: Para 15 of MHPS says this decision should be taken in consultation with the Medical Dir and dir of HR

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 minor shortcomings are ~~isolated~~

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3.4.2 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

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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. ~~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.~~

3.4.4

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 future performance and 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 Staffing Manager. This is not a formal disciplinary sanction.

~~3.4.3~~3.4.5 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 place temporary restrictions on a practitioner's practice. The Medical Staffing Manager must also be informed 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~~n~~ 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. In these situations, a ~~well undertaken~~ thorough and robust investigation and report will help to clarify any action needed. The decision following the initial screening, can therefore result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

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 formal process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner

Commented [JT18]: Not sure that a warning is appropriate for performance issues??

Commented [JT19]: There are 2 separate points in this para. Firstly re restrictions. See page 8 of the NCAS guide. I think it is probably worth noting that any voluntary agreement re restrictions should be recorded in writing including any undertaking to apply the same restrictions in any practice elsewhere. Probably also worth saying that the least restrictive option should be adopted consistent with patient safety etc. The second point relates to immediate exclusion. I think there should be a separate para for this and further guidance needs to be provided about immediate exclusion.

Commented [JT20]: Quote from the NCAS Guide??

Commented [JT21]: This is a little clumsy. Can this be clarified??

Commented [JT22]: The word formal does not appear in para 30 of MHPS. The right is to be accompanied "at any stage of the process."

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 P~~oint~~ara 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

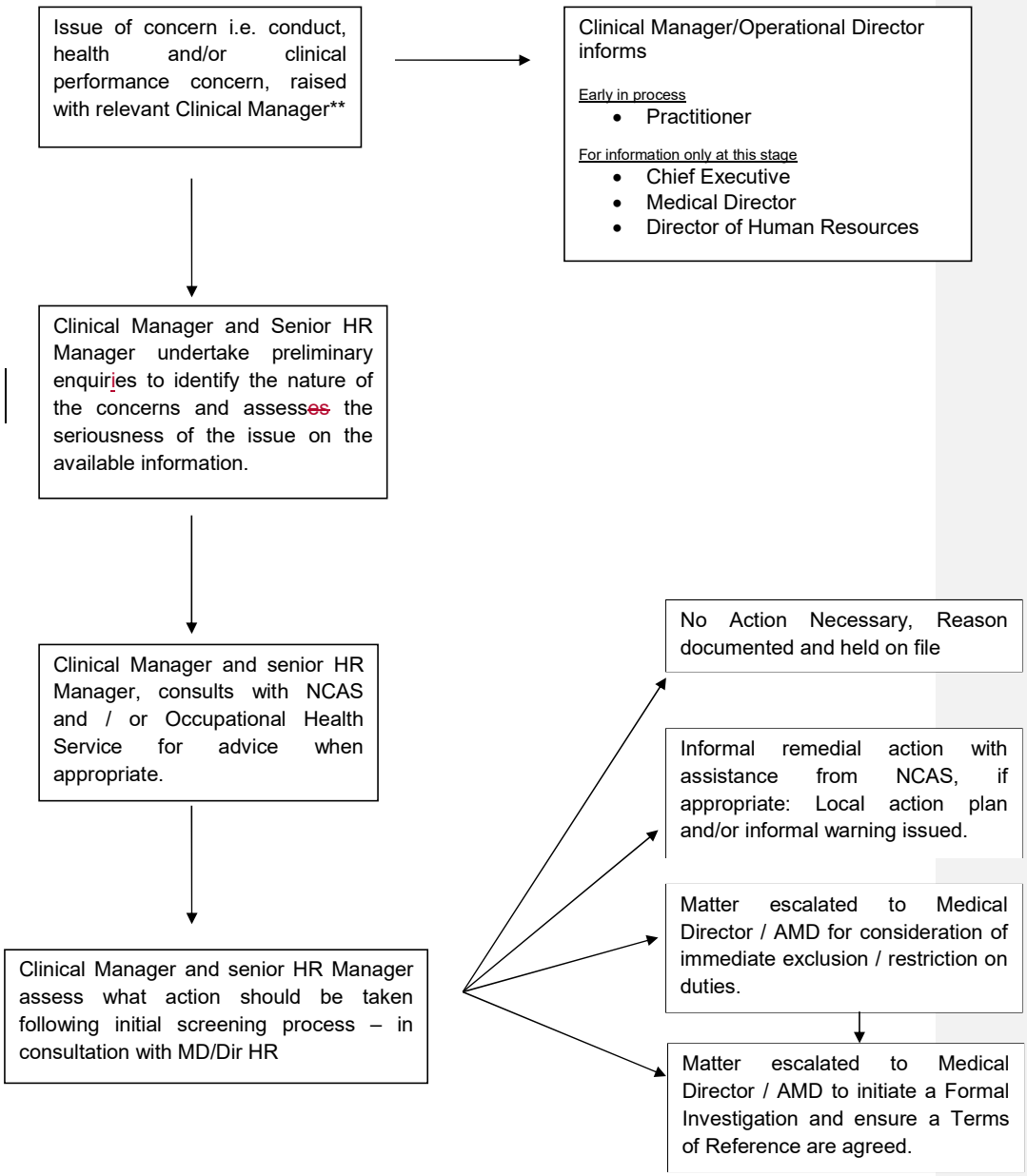
Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Formal E~~e~~xclusion can be used ~~at any stage of the process.~~in the context of a formal investigation

Appendix 6
Role definitions

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

Informal Remedial Action

A determination by the Clinical Manager and senior HR Manager is made to deal with the issues of concern through informal remedial action

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors compliance with agreed plan.

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

Appendix 2

Formal Investigation Process

A determination by the Clinical Manager and senior HR Manager is made to deal with the issues of concern through the formal process.

Medical Director (following discussions with Chief Executive, and HROD), appoints a Case Manager and a Case Investigator.

Chief Executive, following discussions with the Chair, seeks appointment of a designated Board member to oversee the case.

Case Manager informs the Practitioner of the investigation in writing, including the name of the Case Investigator and the specific allegations raised.

Case Manager must ensure the Case Investigator gives the Practitioner an opportunity to see all relevant correspondence, a list of all potential witnesses and give an opportunity for the Practitioner to put forward their case as part of the investigation.

Case Investigator gathers the relevant information, takes written statements and keeps a written record of the investigation and decisions taken.

Case Investigator should, other than in exceptional circumstances complete the investigation within 4 weeks and submit to the Case Manager with a further 5 days. Independent advice should be sought from NCAS.

Case Manager gives the Practitioner an opportunity to comment on the factual content of the report including any mitigation within 10 days.

Case Manager must then make a decision on whether:

1. no further action is needed
2. restrictions on practice or exclusion from work should be considered
3. there is a case of misconduct that should be put to a conduct panel under the Trust's Disciplinary Procedures
4. there are concerns about the Practitioners health that needs referred to the Trust's Occupational Service for a report of their findings (Refer to MHPS Section V)
5. there are concerns about clinical performance which require further formal consideration by NCAS
6. there are serious concerns that fall into the criteria for referral to the GMC or GDC by the Medical Director/Responsible Officer
7. there are intractable problems and the matter should be put before a clinical performance panel.

Commented [JT23]: 3rd box down – Case Investigator does not take decisions other than relating to the conduct of the investigation

Appendix 3

Outcome of Formal Investigation:
Conduct Hearings / Disciplinary Procedures

Following the formal investigation, the Case Manager makes the decision that there is a case of misconduct that must be referred to a conduct panel. This may include both personal and professional misconduct.

Case Manager informs:
- Chief Executive
- Designated Board member
- Practitioner

↓

Case referred under the Trust's Disciplinary Procedures. Refer to these procedures for organising a hearing.

↓

If a case identifies issues of professional misconduct:
- The Case Investigator must obtain appropriate independent professional advice
- The conduct panel at hearing must include a member who is medically qualified and who is not employed by the Trust.
- The Trust should seek advice from NCAS
- The Trust should ensure jointly agreed procedures are in place with universities for dealing with concerns about Practitioners with joint appointment contracts

↓

If the Practitioner considers that the case has been wrongly classified as misconduct, they are entitled to use the Trust's Grievance Procedure or make representations to the designated Board Member.

In all cases following a conduct panel (Disciplinary Hearing), where an allegation of misconduct has been upheld consideration must be given to a referral to the GMC/GDC by the Medical Director/Responsible Officer.

If an investigation establishes suspected criminal act~~ion~~(s), the Trust must report the matter to the police. In cases of Fraud the Counter Fraud and ~~Security Management~~ Probity Service of BSO must be considered. This can be considered at any stage of the investigation.

Consideration must also been given to referrals to the Independent Safeguarding Authority or to an alert being issued by the Chief ~~Professional~~ Medical Officer at the ~~DHSSPS~~ DOH or other external bodies.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

Appendix 3a

Outcome of Formal Investigation:
Clinical Performance Hearings

Commented [JT24]: It may be wise to refer to what MHPS says about mixed cases involving issues of both conduct and clinical performance.

Following the formal investigation, the 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
- 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.

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

During the hearing:
- The panel, panel advisors, the Practitioner, their representative and the Case Manager must be present at all times
- Witnesses will only be present to give their evidence.
- The Chair is responsible for the proper conduct of the hearing and should introduce all persons present.

During the hearing - witnesses:
- shall confirm any written statement and give supplementary evidence.
- Be questioned by the side calling them
- Be questioned by the other side
- Be questioned by the panel
- Clarify any point to the side who has called them but not raise any new evidence.

During the hearing – order of presentation:
- Case Manager presents the management case calling any witnesses
- Case Manager clarifies any points for the panel on the request of the Chair.
- The Practitioner (or their Rep) presents the Practitioner's case calling any witnesses.
- Practitioner (or Rep) clarifies any points for the panel on the request of the Chair.
- Case Manager presents summary points
- Practitioner (or Rep) presents summary points and may introduce any mitigation
- Panel retires to consider its decision.

Decision of the panel may be:
1. Unfounded Allegations – Practitioner exonerated
2. A finding of unsatisfactory clinical performance (Refer to MHPS Section IV point 16 for management of such cases).

If a finding of unsatisfactory clinical performance - consideration must be given to a referral to GMC/GDC.

A record of all findings, decisions and warnings should be kept on the Practitioners HR file. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. The decision must be confirmed in writing to the Practitioner within 10 working days including reasons for the decision, clarification of the right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external body.

Case presented to SMT Governance by the Medical Director and Operational Director to promote learning and for peer review once the case is closed.

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 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.
- 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.

Commented [JT25]: Need to stress generally that the least restrictive option should be taken consistent with patient safety etc.

Commented [JT26]: Need to include the purposes of immediate exclusion per MHPS

Immediate Exclusion

~~Consideration t~~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.

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

Commented [JT27]: I think this flowchart is a little confused. Could be misread as suggesting that formal exclusion is the norm in cases under formal investigation. This flowchart will only be relevant in particularly serious cases where formal exclusion is being considered. This needs to be emphasised. Also, the MHPS requirement to consult with NCAS prior to formal exclusion needs to be emphasised here.

Formal Exclusion

Decision of the Trust is to formally investigate the issues of concern and appropriate individuals appointed to the relevant roles.

Case Investigator, if appointed, produces a preliminary report for the case conference to enable the Case Manager to decide on the appropriate next steps.

The report should include sufficient information for the Case Manager to determine:

- If the allegation appears unfounded
- There is a misconduct issue
- There is a concern about the Practitioner's Clinical Performance
- The case requires further detailed investigation

Case Manager, HR Case Manager, Medical Director and HR Director convene a case conference to determine if it is reasonable and proper to formally exclude the Practitioner. (To include the Chief Executive when the Practitioner is at Consultant level). This should usually be where:

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.

Consideration should be given to whether the Practitioner could continue in or (where there has been an immediate exclusion) could return to work in a limited or alternative capacity.

If the decision is to exclude the Practitioner:

Commented [JT28]: Who is the

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

The Case Manager along with the HR Case Manager must inform the Practitioner of the exclusion, the reasons for the exclusion and given an opportunity to state their case and propose alternatives to exclusion. A record should be kept of all discussions.

The Case Manager must confirm the exclusion decision in writing immediately. Refer to MPHS Section II ~~p~~aras 15 to 21 for details.

All exclusions should be reviewed every 4 weeks by the Case Manager and a report provided to the Chief Executive and Oversight Group. (Refer to MHPS Section II ~~p~~ara 28 for review process.

Appendix 6

Commented [JT29R28]: Who is the Oversight Group??

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 supervising Consultant, 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 screening assessment along with a HR Case Manager.

Commented [JT30]: Earlier in this guidance, it says usually the supervising consultant.

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 ~~the~~ investigation and request~~s~~ 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 nor should he/she make recommendations.

Note: Should the concerns involve a Clinical Director, the Case Manager ~~becomes~~ 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 ~~becomes~~ 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 ~~the Clinical Manager~~ all parties before proceeding with this process.

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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.

Commented [JT31]: The focus of the role under MHPS is to ensure that momentum is maintained and to receive and consider certain representations from the practitioner. Preferable simply to refer to the relevant paras of MHPS. The reference to ensuring a "fair and transparent" process may be broadening out their role beyond the strict requirements.

Toal, Vivienne

From: Parks, Zoe
Sent: 06 June 2022 15:26
To: Parks, Zoe
Subject: FW: **DRAFT PAPER - FOR COMMENTS** Trust Guidelines for Handling Concerns about Doctors' & Dentists' Performance
Attachments: DRAFT SHSCT - Trust Guidelines for Handling Concerns about Doctors Dent....doc

Importance: High

From: Tariq, S <Personal Information redacted by the USI>
Sent: 28 November 2017 17:12
To: Parks, Zoe <Personal Information redacted by the USI>
Subject: FW: **DRAFT PAPER - FOR COMMENTS** Trust Guidelines for Handling Concerns about Doctors' & Dentists' Performance
Importance: High

All looks good to me.

Shahid

From: McNeice, Andrea
Sent: 24 November 2017 14:28
To: Chada, Neta; Haynes, Mark; Hogan, Martina; Khan, Ahmed; Murphy, Philip; Scullion, Damian; Tariq, S; Wright, Richard
Cc: Parks, Zoe
Subject: RE: **DRAFT PAPER - FOR COMMENTS** Trust Guidelines for Handling Concerns about Doctors' & Dentists' Performance
Importance: High

Dear all,

Just a gentle reminder to forward your comments/approval on the attached paper to Zoe by Monday, 27 November 2017.

Many thanks,

Andrea

Andrea McNeice
Medical Staffing Unit
The Brackens
CRAIGAVON AREA HOSPITAL
68 Lurgan Road
PORTADOWN BT63 5QQ
(Working Hours - Mon to Fri: 8am – 4pm)

Email: Personal Information redacted by the USI

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

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From: McNeice, Andrea
Sent: 10 November 2017 11:53
To: Chada, Neta; Haynes, Mark; Hogan, Martina; Khan, Ahmed; Murphy, Philip; Scullion, Damian; Tariq, S; Wright, Richard
Cc: Parks, Zoe
Subject: **DRAFT PAPER - FOR COMMENTS** Trust Guidelines for Handling Concerns about Doctors' & Dentists' Performance
Importance: High

Dear all,

Zoe would welcome your comments / approval on the attached paper on or before Monday, 27 November 2017.

Thanking you in advance.

Andrea

Obo Zoe Parks

Andrea McNeice
Medical Staffing Unit
The Brackens
CRAIGAVON AREA HOSPITAL
68 Lurgan Road
PORTADOWN BT63 5QQ
(Working Hours - Mon to Fri: 8am – 4pm)

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Southern Health and Social Care Trust

HR & MEDICAL DIRECTORATE MEETING

Friday, 1st December 2017 at 11:00am in Vivienne Toal's office, Trust HQ, Craigavon Area Hospital

1. **Medical MHPS Cases, Doctors in Difficulty, GMC & NIMDTA Issues**

STRICTLY PRIVATE & CONFIDENTIAL

Personal information redacted by USI:

Simon informed the group of a case involving a doctor who had been working as an F2 in DHH at the time. Dr Personal Information redacted by the USI had prescribed an inappropriate dose of insulin to a patient and unfortunately the patient had died. The GMC had now commenced a preliminary enquiry into this case

Dr Personal Information redacted by the USI:

This case has been closed. Dr Personal Information has paid back all private monies owed and an informal warning has been recorded on his file.

Mr A O'Brien:

Zoe advised the group Siobhan had provided an update to indicate that Mr O'Brien has indicated he would like to respond to some concerns he has about witness statements. Following that, the final report can be completed. There may also be a need to involve NCAS.

Action: Simon Gibson to find out from Esther who is supervising Mr O'Brien

Dr Personal Information:

Zoe advised that an oversight group meeting needed to be arranged as the recent meeting had been postponed. The most recent Occupational Health report advised that Dr Personal Information could now work until 9pm, however she is unlikely to be able to work after 9pm until her next review in 6 months' time. It has been decided to advertise for a PT consultant with full on-call duties. Dr Wright advised that her colleagues have indicated they are willing to cover her on-call.

Action: Zoe to ensure the team in DHH are informed of this

Dr Personal Information redacted by the USI

It was agreed that this case should be monitored and reviewed as we understand Dr Personal Information is currently Personal Information redacted by the USI very unwell.

Mr Personal Information:

An anonymous letter highlighting concerns about Mr Personal Information redacted by the USI working together had been received. Helen informed the group that Mr Haynes was to meet with Mr Personal Information to discuss this, but as far as she was aware this had not happened. Mr Personal Information had indicated he would welcome a meeting with someone from HR.

Action: Dr Wright to remind Mr Haynes of the urgent need to take this forward with Mr Personal Information.

FY1 Grievance:
Zoe informed the group that an IT application for loss of earnings has been received from the BMA on behalf of a group of F1 doctors who had been based in DHH between Aug 2016 and Aug 2017. This relates to the outcome of a monitoring exercise. A grievance hearing had been scheduled to take place on 23 November 2017; however this was cancelled at very short notice by the BMA as none of the doctors were available to attend. The grievance hearing needs to be rearranged. It was agreed that the process should be allowed to continue as there are sufficient grounds to challenge this.

Job plan appeal:
Zoe advised that a number of Consultant Anaesthetists had requested a job plan appeal following a change to the Anaesthetics 1st on call rota in CAH. She advised that the Trust had recently advertised for 2 posts and if appointments were made, this could help to resolve the matter.

Dr Personal Information redacted by the USI :
Dr Wright advised that Dr Personal Information was due for revalidation in Feb 2018, however he was not actively engaging in the process.

2. MHPS revised guidelines
It was agreed that the revised guidelines should be added to the next LNC agenda – for information only
Zoe advised that the oversight process had been removed from the guidelines and decision making powers were now with the Case manager.
Action: Zoe to add to next LNC agenda

Educational/Clinical supervisors;
Simon informed the group that there were 19 people who had still not completed the required training modules to allow them to undertake Educational or Clinical Supervisor roles.
Action: it was agreed that Simon should inform the 19 that trainees will be removed if the training is not completed urgently.

3. SAS Development
Zoe advised that a second round of Trust Associate Specialist applications had been completed and two people had been successful. She shared a paper detailing 6 fundamentals for supporting, developing and retaining SAS doctors in the SHSCT and it was agreed this should be added to the AMD agenda for the meeting on 15 December. Dr Wright also asked if the paper could be shared with Dr Sara Landy, LNC SAS rep & Dr N Chapman for their comments.

Simon also suggested that the paper should be presented at the SAS regional conference on 26th April 2018.

4. Physician Associate Recruitment
Malcolm updated the group on a teleconference that had taken place to discuss forthcoming Physician Associate placements. He advised that a number of clinical governance concerns had been raised by clinicians at the meeting (e.g. need for chaperone when seeing patients, read-only access to x-ray/labs etc) however all parties agreed we had no choice but to press ahead and learn from this, bearing in mind that students were due to start their placements on 22 January 2018. Malcolm informed the group that Annie Buchanan from the University of Ulster was keen to visit Clinical and Educational Supervisors to agree expectations and get a feel for what the departments could deliver.
Simon advised that the closing date for the Clinical Lead posts was Monday 4 December 2017.

Action: Medical staffing to proceed with advertising for fully qualified Physician Associates. It was agreed that the job description should remain quite general across a range of specialties depending on experience

5. LNC Action points – to be confirmed

6, 7, & 8 - It was agreed that agenda items 6, 7 and 8 should be deferred as these had been raised by Vivienne and she was not able to attend the meeting.

9. Any other business

TIG Process – Dr Wright should be informed of any posts we are planning to advertise. He will share this informally with other Medical Director's for information, however this was not to seek approval and it should not hold up the process

Study Leave – Malcolm informed the group he had received feedback from Dr Maguire in support of Selective Travel. His experiences of Selective Travel had been very positive.
Action: It was agreed that the Medical Director's office should update the Study Leave policy to reflect this

Junior doctor rotas – Malcolm informed the group that there were a number of junior doctor rotas that were vulnerable or at risk. For example some rotas were dependent on locum doctors filling rota slots and in most cases the Trust was not funded for these. In other cases here were too few juniors available to run separate rotas e.g. surgical specialties.
Action: Dr Wright/ Simon to identify a Clinical Director to take responsibility for this or perhaps to approach Dr Ken Lowry with a view to overseeing this.

10. Date of next meeting

Friday 5th January 2018 @ 2.00pm in the Meeting Room, Trust HQ

Toal, Vivienne

From: Parks, Zoe
Sent: 06 June 2022 15:31
To: Toal, Vivienne; Hynds, Siobhan
Subject: FW: SHSCT - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 24 OCTOBER 2017
Attachments: DRAFT SHSCT - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 24 OCTOBER 2017.pdf; FW: **DRAFT PAPER - FOR COMMENTS** Trust Guidelines for Handling Concerns about Doctors' & Dentists' Performance; FW: Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 24 OCTOBER 2017

Follow Up Flag: Follow up
Flag Status: Completed

Categories: UPI, NOTED

It seems to have been circulated around all the AMD's and MD in Nov 17 - Chada, Neta; Haynes, Mark; Hogan, Martina; Khan, Ahmed; Murphy, Philip; Scullion, Damian; Tariq, S; Wright, Richard

It then seems to have then been shared with LNC in March 18 (see below)

See attached

From: Parks, Zoe <Personal Information redacted by the USI>
Sent: 02 March 2018 16:18
To: C Neely email address>; Maguire, Peter <Personal Information redacted by the USI>
Subject: SHSCT - Trust Guideline for Handling Concerns about Doctors Dentists Performance (MHPS) FINAL 24 OCTOBER 2017

As referenced at the recent LNC informal meeting – please find attached the revised **Trust Guidance for handling concerns about Doctors/Dentists**. This sits alongside the MHPS framework document to clarify some of the Trust responsibilities

Zoë

Zoe Parks
Head of Medical Staffing HROD
Southern Health & Social Care Trust
Personal Information redacted by the USI
My working days are Tuesday-Friday

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

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MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN NHS

Maintaining High Professional Standards in the Modern NHS

Introduction

In December 2003, the Department of Health issued the document *High Professional Standards in the Modern NHS; a framework for the initial handling of concerns about doctors and dentists in the NHS*, under cover of HSC 2003/012. The framework consisted of two parts:

Part I: Action when a concern arises; and
Part II: Restriction of practice and exclusion.

The Department has now agreed with the British Medical Association and British Dental Association the remaining three parts of the framework covering new disciplinary procedures for doctors and dentists employed in the NHS. These are:

Part III: Conduct hearings and disciplinary matters;
Part IV: Procedures for dealing with issues of capability; and
Part V: Handling concerns about a practitioner's health.

As with Parts I and II, Parts III, IV, and V of the framework have been drafted in close collaboration with NHS Employers and the National Clinical Assessment Authority.

The new procedure replaces the current disciplinary procedures contained in circular HC(90)9, as well as the Special Professional Panels ("the three wise men) provided for in HC(82)13 and abolishes the right of appeal to the Secretary of State held by certain practitioners under Para 190 of the Terms and Conditions of Service. The Directions on Disciplinary Procedures 2005 require all NHS bodies in England to implement the framework within their local procedures by 1 June 2005. It has also been agreed with Monitor that the framework should be issued to NHS Foundation Trusts as advice.

Key Changes

The key changes are that:

- the distinction between personal and professional misconduct is abolished. Doctors and dentists employed in the NHS will be disciplined for misconduct under the same locally based procedures as any other staff member;
- there is a single process for handling capability issues about the practitioners professional competence closely tied in with the work of the National Clinical Assessment Authority;
- Health issues are routinely dealt with through the occupational health service;
- The employing Trust is squarely responsible for the disciplining of its medical and dental staff – not outsiders;
- There is scope bring in expert advice for panels considering capability issues;
- The capability panel will be handled by an independent chair;
- The same disciplinary procedures will apply to all doctors and dentists employed in the NHS.

Doctors' and dentists' disciplinary framework: introduction and explanatory note

NHS organisations are required to have procedures for handling concerns about the conduct, performance and health of medical and dental employees, (excluding those who perform PCT Medical Services for the exercise of those functions, as far as they are covered by the Primary Care List System). Under the Restriction of Practice and Exclusion from Work Directions 2003, and the Directions on Disciplinary Procedures 2004, these local procedures must be in accordance with the framework.

This framework has been developed at a national level by the Department of Health, the NHS Confederation, the British Medical Association and the British Dental Association and applies to the NHS in England. It covers:

- action to be taken when a concern about a doctor or dentist first arises;
- procedures for considering whether there need to be restrictions placed on a doctor or dentists practice or suspension is considered necessary
- guidance on conduct hearings and disciplinary procedures
- procedures for dealing with issues of capability
- arrangements for handling concerns about a practitioners health

Background

1. For a number of years there has been concern about the way in which complaints about, and disciplinary action against, doctors and dentists have been handled in the NHS and particularly about the use of suspension* in such cases. The National Clinical Assessment Authority (NCAA), which was established to improve arrangements for dealing with the poor clinical performance of doctors, has by working with the NHS helped to avoid the suspension, informal suspension and other authorised absences from work of 85% of the cases referred to it where suspension was being contemplated by the NHS Trust. The number of doctors and dentists who have been suspended from work for long periods is a cause for concern. Although the numbers are small the costs to the NHS are substantial.

* The term exclusion from work is used in this document 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 the hearing.

Table 1. Number of doctors and dentists suspended for six months or more.

Quarter	2000	2001	2002	2003
1.	33	32	30	27
2.	30	33	33	26
3.	26	33	38	32
4.	27	29	29	24

Changes to NHS disciplinary procedures are necessary as a result of the introduction of Shifting the Balance of Power, the Employment Act 2002 and the Follett report ("A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties" A report to the Secretary of State for Education and Skills, by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001).

2. Developing new arrangements for handling issues about medical and dental staff performance has become increasingly important both to tackle these concerns and to reflect the new systems for quality assurance and quality improvement which have been introduced in the NHS in recent years.

3. The new approach set out in the framework 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;
  *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. Appraisal is a contractual requirement for NHS consultants and GP Principals.

- the advisory and assessment services of the NCAA - aimed at enabling NHS Trusts 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;

- abandoning the "suspension culture" - by introducing the new arrangements for handling exclusion from work set out in part II of this framework.

4. But 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 keeping their skills and knowledge up to date; maintaining their competence; and which support an open approach to reporting and tackling concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through disciplinary action. However it is not intended to weaken accountability or avoid disciplinary action where there is genuinely serious misconduct.

Maintaining High Professional Standards in the Modern NHS

I Action when a concern arises

Contents

I. ACTION WHEN A CONCERN ARISES

INTRODUCTION

1.The management of performance is a continuous process which is intended to identify problems. 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 need not necessarily require formal investigation or the resort to disciplinary procedures.

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

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff
- Review of performance against job plans, annual appraisal, revalidation
- Monitoring of data on 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

2. Unfounded and malicious allegations can cause lasting damage to a doctor's reputation and career prospects. Therefore all allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to verify the facts so that the allegations can be shown to be true or false.

FRAMEWORK FOR NHS PROCEDURES

3. All NHS bodies* must have procedures for handling serious concerns about an individual's conduct and capability**. These procedures must reflect the framework in this document and allow for informal resolution of less serious problems. Concerns about the capability of doctors and dentists in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.
*In the Direction and the framework "NHS bodies" means: Strategic Health Authorities, Special Health Authorities, NHS Trusts and Primary Care Trusts.
**A serious concern about capability will arise where the practitioner's actions have or may adversely affect patient care.

4. All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. The Chairman of the

Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. 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. However the issue is raised, the Medical Director* will need to work with the Director/Head of HR to decide the appropriate course of action in each case. The Medical Director will act as the case manager in cases involving clinical directors and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases. The Medical Director is responsible for appointing a case investigator. **In bodies that do not have a Medical Director, the Chief Executive should designate a senior clinical manager to perform the role assigned to the Medical Director in these procedures and ensure that they are appropriately trained.

Protecting the public

5. When serious concerns are raised about a practitioner, the employer must 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. Part II of this framework sets out the procedures for this action.

6. The duty to protect patients is paramount. At any point in the process where the case manager has reached the clear judgement that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the regulatory body, whether or not the case has been referred to the NCAA*. Consideration should also be given to whether the issue of an alert letter should be requested. *The GMC or GDC will discuss with the NCAA whether any immediate action is needed by the GMC/GDC or whether the NCAA's consideration should continue.

Involving the NCAA

7. At any stage of the handling of a case consideration should be given to the involvement of the NCAA. The NCAA has developed a staged approach to the services it provides NHS Trusts and practitioners. This involves:

- Immediate telephone advice, available 24 hours
- Advice, then detailed supported local case management
- Advice, then supported local clinical performance assessment
- Advice, then detailed NCAA clinical performance assessment
- Support with implementation of recommendations arising from assessment
- Understanding the issue and investigation

SUMMARY OF KEY ACTION:

- Clarify what has happened and the nature of the problem or concern;
- Discuss with the NCAA what the way forward should be;
- Consider whether restriction of practice or exclusion is required;
- If a formal approach under the conduct or capability procedures is required, appoint an investigator;
- If the case can be progressed by mutual agreement consider whether an NCAA assessment would help clarify the underlying factors that led to the concerns and assist with identifying the solution.

8. The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with the Director/Head of HR and the Medical Director and the National Clinical Assessment Authority (NCAA). The NCAA can provide a sounding board for the case manager's first thoughts. However, the NCAA asks that the first approach to them should be made by the NHS body's Chief Executive or Medical Director. Where there are concerns about a doctor or dentist in training, the postgraduate dean should be involved as soon as possible.

9. The first stage of the NCAA's involvement in a case is exploratory- an opportunity for local managers to discuss the problem with an impartial outsider, to look afresh at a problem, see new ways of tackling it themselves, possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than the NCAA.

10. Having discussed the case with the NCAA, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen the NCAA can still be involved until the problem is resolved. This can include the NCAA undertaking a formal clinical performance assessment when the doctor, the NHS body and the NCAA agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps. If the NCAA is asked to undertake an assessment of the doctor's practice, the outcome of a local investigation may be made available to inform the NCAA's work.

11. Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Director/Head of Human Resources, 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 should be appropriately trained, to enable them to carry out this role when required.

12. The case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The case investigator:

- must formally involve a senior member of the medical or dental staff* where a question of clinical judgement is raised during the investigation process.
  *Where no other suitable senior doctor or dentist is employed by the NHS body a senior doctor or dentist from another NHS body should be involved.

- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but the disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered.

- must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene a disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report.

- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Director or Head of HR with the Medical Director.

- must assist the designated Board member in reviewing the progress of the case.

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

13. The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided, that an investigation is to be undertaken, the name of the case investigator and made aware of 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 that 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.

14. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body; an official or lay representative of the British Medical Association, British Dental Association or defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity.

15. 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. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter

16. 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.

17. 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 report of the investigation should give the case manager sufficient information to make a decision whether:

- 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 NHS body's occupational health service;
- there are concerns about the practitioner's performance that should be further explored by the National Clinical Assessment Authority;
- restrictions on practice or exclusion from work should be considered;
- there are serious concerns that should be referred to the GMC or GDC;
- there are intractable problems and the matter should be put before a capability panel;
- No further action is needed.

Involvement of the NCAA following local investigation

18. Medical under performance can be due to health problems, difficulties in the work environment, behaviour or a lack of clinical capability. These may occur in isolation or in a combination. The NCAA's processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. The NCAA's methods of working therefore assume commitment by all parties to take part constructively in a referral to the NCAA. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.

19. The focus of the NCAA's work is therefore likely to involve performance difficulties which are serious and/or repetitive. That means:

Performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk.

Alternatively or additionally, problems that are ongoing or (depending on severity) have been encountered on at least two occasions.

In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process. The NCAA may advise on this.

20. Where an employing body is considering excluding a doctor or dentist whether or not his or her performance is under discussion with the NCAA, it is important for the NCAA to know of this at an early stage, so that alternatives to exclusion can be considered. Procedures for exclusion are covered in part II of the framework. It is particularly desirable to find an alternative when the NCAA is likely to be involved, because it is much more difficult to assess a doctor who is excluded from practice than one who is working.

21. A practitioner undergoing assessment by the NCAA must cooperate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the NCAA assessment is complete*. The NCAA has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk/services.

*Under circular HSC 2002/011, Annex 1, paragraph 3, "A doctor undergoing assessment by the NCAA must give a binding undertaking not to practise in the NHS or private sector other than in their main place of NHS employment until the assessment process is complete."

22. Failure to co-operate with a referral to the NCAA may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the employer on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the

parties and may necessitate disciplinary action and consideration of referral to the GMC or GDC.

Confidentiality

23. Employers must 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 Employer should only confirm that an investigation or disciplinary hearing is underway.

24. Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose, nor disproportionate to the seriousness of the matter under investigation. Employers should be familiar with the guiding principles of the Data Protection Act.

Transitional arrangements

25. At the time of the implementation of this framework, a case manager must be appointed for all existing cases and the new procedures followed as far as is practical taking into account the stage the case has reached.

26. Where, in the view of the employer, an existing case could not be effectively resolved using this framework and a disciplinary process began before the Directions came into force, an alternative process may be used.

Maintaining High Professional Standards in the Modern NHS

II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

Contents

Restriction of practice and exclusion from work

Introduction

1. This part of the framework replaces the guidance in HSG (94)49*. Under the Restriction of Practice and Exclusion from Work Directions 2003 ("the directions"), NHS employers must incorporate these principles and procedures within their local procedures.
*HSG(94)49- Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff. Department of Health, 1994.

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 the fitness to practise hearing.

3. The Direction requires that NHS 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 Chief Executive and the Board;
- a detailed report is provided when requested to a single non-executive member of the Board (the "Designated Board Member") who will be responsible for monitoring the situation until the exclusion has been lifted.

Managing the risk to patients

4. When serious concerns are raised about a practitioner, the employer must 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 should be involved as soon as possible.

5. 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 ("suspension") should be reserved for only the most exceptional circumstances.

6. 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.

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 on the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

7. Alternative ways to manage risks, avoiding exclusion, 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 the latter might include some formal retraining or re-skilling.

- Sick leave for the investigation of specific health problems.

8. In cases relating to the capability of a practitioner, consideration should be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach should be sought from the National Clinical Assessment Authority (NCAA). If the nature of the problem and a workable remedy cannot be determined in this way, the case manager should seek to agree with the practitioner to refer the case to the NCAA, which can assess the problem in more depth and give advice on any action necessary. The NCAA can offer immediate telephone advice to case managers considering restriction of practise or exclusion and, whether or not the practitioner is excluded, provide an analysis of the situation and offer advice to the case manager.

THE EXCLUSION PROCESS

9. Under the Direction, a NHS 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 features of Exclusion from Work

- An initial "immediate" exclusion of no more than two weeks if warranted;
- Notification of the NCAA before formal exclusion;
- Formal exclusion (if necessary) for periods up to four weeks;
- Advice on the case management plan from the NCAA;
- Appointment of a Board member to monitor the exclusion and subsequent action;
- Referral to NCAA 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.

Roles of officers

10. The Chief Executive of the employing organisation has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by persons nominated under paragraph 12. The case should be discussed fully with the Chief Executive, the Medical Director, the Director/Head of Human Resources, the NCAA and other interested parties (such as the police where there are serious criminal allegations or the Counter Fraud & Security Management Service) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

11. The authority to exclude a member of staff must be vested in a nominated manager or managers of the NHS body. 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 Chief Executive, Medical Director and the Clinical Directors for staff below the grade of consultant.

12. The Medical Director will act as the case manager or delegate this role 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 investigating officer will provide factual information to assist the case manager in reviewing the need for exclusion and making reports on progress to the Chief Executive or designated Board member.

Role of designated Board member

13. Representations may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights (which, broadly speaking, sets out the framework of the rights to a fair trial).

Immediate exclusion

14. An immediate time limited exclusion may be necessary for the purposes identified in paragraph 6 above following:

- a critical incident when serious allegations have been made; or
- there has been a break down in relationships between a colleague and the rest of the team; or
- the presence of the practitioner is likely to hinder the investigation.

Such an exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to contact the NCAA for advice and to convene a case conference. The manager making the exclusion must explain why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date up to a maximum of two weeks away at which the practitioner should return to the workplace for a further meeting. The case manager must advise the practitioner of their rights, including rights of representation.

Formal exclusion

15. A formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. The NCAA 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.

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

- the allegation appears unfounded; or
- there is a misconduct issue; or
- there is a concern about the practitioner's capability; or
- the complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be inquired into.

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

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

- allegations of misconduct,
- concerns about serious dysfunctions in the operation of a clinical service,
- concerns about lack of capability or poor performance of sufficient,
- seriousness that it is warranted to protect patients;

or

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

18. Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

19. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of 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 NCAA with voluntary restriction).

20. The formal exclusion must be confirmed in writing as soon as is reasonably practicable. 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 23, and the need to remain available for work paragraph 24) and that a full investigation or what other action will follow. The practitioner and their companion should 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.

21. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week renewable 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. 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.

22. 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 to the NCAA for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period the principle of four-week "renewability" must be adhered to.

23. 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 SHA and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

Exclusion from premises

24. Practitioners should not be automatically barred from the premises upon exclusion from work. Case managers must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where the practitioner may be a serious potential danger to patients or other staff. In other circumstances, however, there may be no reason to exclude the practitioner from the premises. The practitioner may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

Keeping in contact and availability for work

25. As exclusion under this framework should usually be on full pay, the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continuing to undertake such work or to take annual leave or study leave. 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).

26. The case manager should make arrangements to ensure that the practitioner can keep in contact with colleagues on professional developments, and take part in Continuing Professional development (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.

Informing other organisations

27. In cases where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) 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 NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer*.

*NHS 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 honorary contracts. A draft model protocol is available from the Department of Health.

28. Where the case manager believes that the practitioner is practising in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, he or she should contact the professional regulatory body and the Director of Public Health or Medical Director of the Strategic Health Authority to consider the issue of an alert letter.

Informal exclusion

29. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been commonly used in the recent past. No NHS body may use "gardening leave" as a means of resolving a problem covered by this framework.

Existing suspensions & transitional arrangements

30. At the time of 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.

31. A case manager should be appointed for each existing case and a review conducted of the need for the suspension as in paragraph 33 below. In cases where exclusion is considered to be necessary, the new system will apply and the exclusion will be covered by the four-week review rule set out below. The new exclusion will run for four weeks in the first instance.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the Board

32. 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:

- require a summary 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;
- 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 Strategic Health Authority.

Regular review

33. The case manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive and the Board*. This report is advisory and it would be for the case manager to decide on the next steps as appropriate. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. 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.

*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.

34. The NHS body must take review action before the end of each 4-week period. After three exclusions, the NCAA must be called in. The table below outlines the various activities that must be undertaken at different stages of exclusion.

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 next steps as appropriate. Further renewal may be for up to 4 weeks at a time.

- Case manager submits advisory report of outcome to Chief Executive and the Board.
- Each renewal is a formal matter and must be documented as such.
- The practitioner must be sent written notification on each occasion.
- Third review

If the practitioner has been excluded for three periods:

- A report must be made 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 CE must report to the Strategic Health Authority (SHA) (see paragraphs 36-38 below) and the designate Board member (see paragraphs 41-42 below).

- The case must formally be referred to the National Clinical Assessment Authority (NCAA) explaining:
  - Why continued exclusion is appropriate
  - What steps are being taken to conclude the exclusion at the earliest opportunity

- The NCAA will review the case with the SHA and advise the NHS body on the handling of the case until it is concluded.

6 months review

If the exclusion has been extended over six months,

- A further position report must be made by the Chief Executive to the SHA indicating:
  - the reason for continuing the exclusion;
  - anticipated time scale for completing the process;
  - actual and anticipated 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 advice they can offer to the Board.

35. 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 NCAA should actively review those cases at least every six months.

The role of the SHA in monitoring exclusions

36. When the SHA is notified of an exclusion, it should ensure that the NCAA has also been notified.

37. When an exclusion decision has been extended twice, the Chief Executive of the employing organisation (or a nominated officer) must inform the SHA of what action is proposed to resolve the situation. This should include dates for hearings or give reasons for the delay. Where retraining or other rehabilitation action is proposed, the reason for continued exclusion must be given.

38. The SHA will receive the monthly statistical summary given to Boards and collate them into a single report for the Department of Health.

The role of the Board and designated member

39. The Board has a responsibility for ensuring that these procedures are established and followed. It is also responsible for ensuring the proper corporate governance of the organisation, and for this purpose reports must be made to the Board under these procedures.

40. 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 each review.

41. The Board is responsible for designating one of its non-executive members as a "designated Board member" under these procedures. The designated Board member is the person who oversees the case manager and investigating manager during the investigation process and maintains momentum of the process.

42. This member's responsibilities include:

- receiving reports and reviewing the continued exclusion from work of the practitioner;
- considering any representations from the practitioner about his or her exclusion;
- considering any representations about the investigation;

RETURN TO WORK

43. 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 or what the duties and restrictions are to be and any monitoring arrangements to ensure patient safety.

Maintaining High Professional Standards in the Modern NHS

III Conduct hearings and disciplinary matters

Contents

Maintaining High Professional Standards in the Modern NHS

III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

1. Misconduct matters for doctors and dentists, as for all other staff groups, are matters for local employers and must be resolved locally. All issues regarding the misconduct of doctors and dentists should be dealt with under the employer's procedures covering other staff charged with similar matters. Employers are nevertheless strongly advised to seek advice from the NCAA in conduct cases, particularly in cases of professional conduct.

2. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional conduct 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. [1]

3. NHS 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 honorary contracts.

Codes of Conduct

4. Every NHS 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:

[1] 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 medical staff committee or local negotiating committee

- A refusal to comply with reasonable requirements of the employer.
- An infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required by doctors and dentists by their regulatory body[2].
- 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.

5. Examples of misconduct will vary greatly. 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 ACAS 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.

6. Any allegation of misconduct against a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset.

7. 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.

8. Each case must be investigated, but as a general rule no employee should be dismissed for a first offence, unless it is one of gross misconduct.

9. It is for the employer to decide upon the most appropriate way forward, having consulted the NCAA and their own employment law specialist. 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. Many smaller organisations such as Primary Care Trusts, may not have all the necessary personnel in place to follow the procedures outlined in this

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

document. For example, some PCTs 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.

11. Such organisations should consider working in collaboration with other local NHS organisations (eg other PCTs or larger employers) 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 NHS organisation should contact the NCAA to take its advice on the process followed and ensure that it is in accordance with the policy and procedure set out in this document.

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

12. 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 which are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

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

13. 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 consider 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 job 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 job, 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

14. When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but the employer feels there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to ensure that the individual concerned does not pose a risk to patient safety. 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 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. Where charges are dropped, the presumption is that the employee will be reinstated.

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

15. 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 either appropriate investigations being carried out and reports made or referral to the appropriate regulatory body.
- Payment will not normally be made when a member of staff's employment is terminated on disciplinary grounds or following the resignation of the member of staff.
- Expenditure on termination payments must represent value for money. For example, the Trust should be able to defend the settlement on the basis that it could conclude the matter at less cost than other options. A clear record must be kept, setting out the calculations, assumptions and rationale of all decisions taken, to show that the Trust or authority has taken into account all relevant factors, including legal advice. The audit trail must also show that the matter has been considered and approved by the remuneration committee and the Board. It must also be able to stand up to district auditor and public scrutiny.
- Offers of compensation, as an inducement to secure the voluntary resignation of an individual, must not be used as an alternative to the disciplinary process.

- All job references must be accurate, realistic and comprehensive and under no circumstance may they be misleading.

- Where a termination settlement is agreed, details may be confirmed in a Deed of Compromise that should set out what each party may say in public or write about the settlement. The Deed of Compromise is for the protection of each party, but it must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an open reference.[3]

[3] For the purposes of this paragraph, an open reference is one that is prepared in advance of a request by a prospective employer.

Maintaining High Professional Standards in the Modern NHS

IV Procedures for dealing with issues of capability

Contents

Maintaining High Professional Standards in the Modern NHS

IV. PROCEDURES FOR DEALING WITH ISSUES OF CAPABILITY

INTRODUCTION & GENERAL PRINCIPLES

1. 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 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.

2. The National Patient Safety Agency (NPSA) was established to co-ordinate the efforts of all those involved in healthcare to learn from adverse incidents occurring within the NHS. In particular, the NPSA aims to facilitate the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses in a climate free from fear of personal reprimand, where the sharing of experience helps others to learn lessons and in turn improve patient safety.

3. However, there will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues. Matters that should be described and dealt with as misconduct issues are covered in part III of this framework.

4. Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from the National Clinical Assessment Authority (NCAA)[4] will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, the matter must be referred to the NCAA before the matter can be considered by a capability panel (unless the practitioner refuses to have his or her case referred). Employers are also strongly advised to involve the NCAA in all other cases particularly those involving professional conduct.

[4] or successor body

5. Matters which may fall under the capability procedures include:

Some examples of concerns about capability

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

6. Wherever possible, employers should aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. The NCAA has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and should be consulted. A web based toolkit has been developed and is available at: www.ncaa.nhs.uk/toolkit

7. Any concerns about capability relating to a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor, with close involvement of the postgraduate dean from the outset.

How to proceed where conduct and capability issues involved

8. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability 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 NCAA adviser and their own employment law specialist.

Duties of Employers

9. The procedures set out below are designed to cover issues where a doctor's or dentist's *capability* to practise is in question[5]. Prior to instigating these procedures, the employer should consider the scope for resolving the issue through counselling or retraining and should take advice from the NCAA.

[5] see paragraph 3 in Part III concerning clinical academics and paragraphs 9 and 10 in Part III on arrangements for small organisations.

10. Capability may be affected by ill health. Arrangements for handling concerns about a practitioner's health are described in part V of this framework. Employers must follow their own procedure for dealing with ill health – including obtaining advice, usually from a consultant Occupational Health Physician.

11. Employers must ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds.

12. Employers must ensure that managers and case investigators receive appropriate and effective training in the operation of capability procedures. Those undertaking investigations or sitting on capability 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 must have completed before they can take a part in these proceedings.

CAPABILITY PROCEDURE

The pre-hearing process

13. When a report of the Trust investigation (as in Part I[6]) has been received, 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.

14. The case manager should 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 NCAA. The case manager will need to consider urgently:

    - whether action under Part II of the framework is necessary to exclude the practitioner; or
    - to place temporary restrictions on their clinical duties.

    The case manager will also need to consider with the Medical Director and head of Human Resources whether the issues of capability can be

[6] "Action when a concern arises" - Part I of the framework issued under the Restriction of Practise & Exclusion from Work Directions 2003.

resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to the NCAA 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.

15. The NCAA will assist the employer 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 must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by the NCAA, 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 NCAA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.
16. If the practitioner does not agree to the case being referred to the NCAA, a panel hearing will normally be necessary.

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

Procedure to be followed prior to capability hearings

- The case manager must 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.

- All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing.

- Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that 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), 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 capability 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 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

18. The capability 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 a medical or dental practitioner who is not employed by the Trust.[7] As far as is reasonably possible or practical, no member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

19. Arrangements must be made for the panel to be advised by:

- A senior member of staff from Human Resources, and
- A senior clinician from the same or similar clinical specialty as the practitioner concerned, but from another NHS employer.
- A representative of a university if provided for in any protocol as mentioned in paragraph 18.

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.

20. 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 capability hearings

21. 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.

[7] 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 medical staff committee or local negotiating committee.

22. The practitioner may be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organisation. 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 capability hearing

23. The hearing should be conducted as follows:
    - The panel and its advisers (see paragraph 19), 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 including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.

- 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 above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.

- 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

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

Possible decisions made by the capability panel

- 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 employee's 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 employee's 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 employee's 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 employer that the panel wishes to comment upon.

25. A record of oral agreements and written warnings should be kept on the practitioner's personnel file but should be removed following the specified period.

26. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Because of the 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.

27. The decision must be confirmed in writing to the practitioner. This notification must 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.

APPEALS PROCEDURES IN CAPABILITY CASES

Introduction

28. Given the significance of the decision of a capability 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 for appeal against decisions of a capability panel. There is no requirement for Trusts to set up a procedure for appeal against exclusion or investigation as these are adjuncts to the stages of the decision making process on what future action to take. The procedure for handling issues about the classification of a case as misconduct is dealt with in paragraph 9 of Part III of this framework.

29. 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 rehear the entire case (see paragraph 31 below).

30. 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 appeal process

31. 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 reheard. 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 capability hearing.

32. Where the appeal is against dismissal, the practitioner should not be paid during the period of appeal, 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 rehear 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

33. The panel should consist of three members. The members of 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.[8] This person is designated Chairman.
- The Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal.
- A medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[9] who must also have the appropriate training for hearing an appeal.
- In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

34. 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 NHS employer. [10]
- A Senior Human Resources specialist.

[8] See Annex A.

[9] 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 medical staff committee or local negotiating committee.

[10] Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

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.

35. The Trust should arrange the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 34. 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.

36. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability 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 Human Resources) 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.

37. 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

38. 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.

39. 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.

40. 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 reheard, on the basis of the new evidence, by a capability hearing panel.

Conduct of appeal hearing

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

42. The practitioner may be represented in the process by a friend, partner or spouse, colleague or a representative who may be from or retained by a trade union or defence organisation. 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.

43. 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.

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

Decision

45. 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

46. Records must 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 must be kept confidential and retained in accordance with the capability 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 Employment Tribunal.

TERMINATION OF EMPLOYMENT WITH PERFORMANCE ISSUE UNRESOLVED

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

48. 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 about the practitioner's capability 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 Act List (held by the Department for Education and Skills).

49. If an excluded employee or an employee facing capability proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures take precedence over the capability 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 Occupational Health Service. The Occupational Health Service will advise the employer on the expected duration of the illness and any consequences it may have for the capability process and 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.

50. 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 his absence.

51. Where a case involves allegations of abuse against a child, the guidance issued to the NHS in September 2000, called "The Protection of Children Act 1999 – A Practical Guide to the Act for all Organisations Working with Children" gives more detailed information. A copy can be found on the Department of Health website[11].

[11] ***A Practical Guide to the Act for all Organisations Working with Children***

Maintaining High Professional Standards in the Modern NHS

Appeal Panels in Capability Cases Annex A

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 national 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 that 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 NHS Appointments Commission*. *NHS Employers* 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, the *NCAA* and *NHS Employers.* These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.

6. The *Department of Health*, in consultation with *NHS 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 competences 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 competences.

7. Panel members will be subject to appraisal against the core competences 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 *NHS Employers* and paid locally by the employing organisation 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 competences and /or seminars designed to provide background on the specific context of NHS disciplinary procedures – including the expectations of employers and representatives, could be provided with support from *NHS Employers*, the *National Clinical Assessment Authorit*y and other stakeholders.

Maintaining High Professional Standards in the Modern NHS

V. Handling concerns about a practitioner's health

Contents

Maintaining High Professional Standards in the Modern NHS

V. HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH

INTRODUCTION

1. 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.

2. The 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 (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS.

Retaining the services of individuals with health problems

3. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk.

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;
- reassign them to a different area of work;
- arrange re-training or adjustments to their working environment , with appropriate advice from the NCAA and/or deanery , under reasonable adjustment provision in the Disability Discrimination Act 1995.

Reasonable adjustment

3. At all times the practitioner should be supported by their employer and the Occupational Health Service who should ensure that the practitioner is offered every available resource to get back to practise where appropriate. Employers should consider what reasonable adjustments could be made to their workplace conditions or other arrangements.

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

5. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency Advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures where appropriate.

HANDLING HEALTH ISSUES

6. Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine a health problem . If the report recommends OHS involvement, the nominated manager must immediately refer the practitioner to a qualified, usually a consultant, occupational physician with the Occupational Health Service.

7. The NCAA should be approached to offer advice on any situation and at any point where the employer is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.

8. The occupational 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 or Head 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)[12]. The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.

9. If a doctor or dentist's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and the professional regulatory body must be informed, irrespective of whether or not they have retired on the grounds of ill health.

10 In those cases where there is impairment of performance solely due to ill health, disciplinary procedures would only be considered in the most exceptional of circumstances , for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by repeatedly refusing a referral to the Occupational Health Service (OHS) or the NCAA. In these circumstances the procedures in part IV should be followed.

11. There will be circumstances where an employee who is subject to disciplinary 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.

12. Special Professional Panels (generally referred to as the "three wise men") were set up by District Health Authorities under circular HC(82)13. This responsibility was not transferred to Trusts and the process has fallen into disuse in most parts of the country. This part of the framework replaces HC(82)13 which is cancelled and any existing panels should be disbanded.

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

Maintaining High Professional Standards in the Modern NHS

Guidance on clinical academics

(including an Outline Protocol between University and Trust)

CLINICAL ACADEMICS

BACKGROUND

The "*Restriction of Practice and Exclusion from Work Directions 2003"* direct NHS bodies to comply with the framework contained within the document *"Maintaining High Professional Standards in the Modern NHS"*. This introduced a new framework for the initial handling and investigation of concerns about the conduct and performance of medical and dental employees. It also introduced a framework for restriction of practice and exclusion from work; it replaces existing guidance on the suspension of doctors and dentists.

In the framework the Department said that NHS 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 honorary contracts. This should be achieved by agreeing a protocol. The draft model protocol mentioned in the framework is attached to this guidance note.

GUIDANCE

1. The Follett report made a number of recommendations about disciplinary procedures. In particular it said:

   "..we are quite clear that here too robust joint working must be the norm. However, we believe that joint working must extend to the prior phase of managing and helping poor performance and seeking remedial measures. It is only when these have run their course without success that formal disciplinary procedures come into play."

2. In discussions with the Universities and Colleges Employers Association (UCEA), Universities UK (UUK), and the Council of Heads of Medical Schools (CHMS), the Department of Health has agreed that the following four key elements are necessary for the successful handling of concerns about a doctor with both an honorary and substantive contract:

   - Appraisals are jointly undertaken by the University and the Trust.

   - The express permission of the doctor involved is obtained for the exchange of both personal data (for example name, address, registration number, qualifications) and sensitive personal data (for example medical records) between University and Trust.

   - Honorary NHS contracts for clinical academic staff contain a clause that states that the employee must have a substantive contract with the University to hold the honorary NHS post, and that, if the University post is terminated, for whatever reason, the Trust reserves the right to review the continuation of the honorary contract (the "inter-dependency clause").

- The Trust and University develop strong, co-partnership relations with each other and ensure jointly agreed procedures are in place for dealing with any concerns about doctors with honorary NHS contracts.

3. Similar arrangements should apply to doctors holding honorary academic contracts with a university.

4. A Revised Model Statute for universities on dismissal, discipline and grievance procedures for academic staff has been approved by the Privy Council, and recommended to universities. It will be for them to decide on implementation. The UCEA has urged them to implement the provisions within the Revised Model Statute relating to clinical academic staff as soon as possible.

5. The success of the contracts rests with the joint working of the university and NHS Trust. Although each employer (university or NHS Trust) can only make a decision to discipline or dismiss a member of staff under its own procedures. It is therefore recommended that a protocol should be agreed to permit the joint working necessary to ensure contractual inter-dependence, if both employers choose that route. Implementation of the Revised Model Statute will enable universities to adopt the new procedures.

6. A draft protocol - “Outline Protocol between University and Trust”- is attached as an appendix. This provides for a good practice way of working, with reference to disciplinary matters and dismissal.

APPENDIX

OUTLINE PROTOCOL BETWEEN UNIVERSITY AND TRUST

1. The following general principles and procedure are the result of agreement between the University and such NHS Trust and Provider Units (hereafter called "the Trust") in which University clinical academic staff may hold honorary NHS contracts and is intended to provide a framework for co-operation between University and Trust as employers of the clinical academic staff.

General Principles

2. The substantive academic contract and the NHS honorary contract are both contracts of employment. The clinical academic will therefore have two employers, each of whom will have obligations to the employee under its respective contract of employment and arising (for example under statute) from the employment relationship generally.

3. However, the University and the Trust recognise that as far as possible those separate employment relationships should be regarded as a whole, reflecting the fact that the performance of the clinical duties under the honorary NHS contract is essential for the full and proper performance of the duties under the substantive academic contract.

4. The University and the Trust should therefore seek to ensure joint co-operation in their dealings with the member of clinical academic staff, in particular with regard to issues of appraisal, review, dismissal and discipline.

Contracts of Employment

5. The University and the Trust will seek to ensure that their contracts (honorary or substantive) contain provisions which facilitate such joint co-operation and shall discuss on a regular basis the contents of the contracts which each will issue to clinical academics.

Disciplinary and other Procedures

6. The University and the Trust acknowledge that as employers of the clinical academic member of staff, each may wish, during the employment of the clinical academic concerned, to take action (whether in terms of dismissal or action falling short of dismissal) in respect of matters such as:

    a) misconduct or alleged misconduct

    b) performance of the duties of employment to a satisfactory standard

    c) assessing medical fitness to undertake all or part of the duties of employment (including consideration of the making of reasonable adjustments under the Disability Discrimination Act 1995 where the obligation to make such adjustments applies)

    d) attendance

    e) redundancy or other re-organisation

7. The University and the Trust acknowledge that each has the following procedures for determining such issues in respect of its relationship with the member of clinical academic staff:- [list the relevant procedures]

8. The University and the Trust acknowledge that:

   a) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s), and the Trust does not (and *vice versa*);

   b) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s) and the Trust also has grounds for considering action against the same employee under its own appropriate procedure(s); and

   c) that if the University or the Trust terminates the substantive or honorary contract (as the case may be), the other will need to consider whether, in the light of that termination, the remaining contract can be continued or ought to be terminated and that, while each case will need to be considered on its own facts, it is appropriate for the University and the Trust to agree in general terms a framework for the handling of such matters.

9. The University and the Trust therefore agree that:

   a) the following issues of conduct are matters which would ordinarily fall to be dealt with under the University's disciplinary procedure(s) [give details];

   b) the following issues of conduct are matters which would ordinarily fall to be dealt with under the Trust's disciplinary procedure(s) [give details]; and

   c) in cases where an issue of misconduct arises under both (a) and (b) above, the University and the Trust will need to determine on the facts of each case which procedure will take priority.

Potential Dismissal on the Grounds of Misconduct

10. Where either the University or the Trust has grounds for considering the dismissal of a member of clinical academic staff on the grounds of misconduct:

    a) the party considering the instigation of disciplinary procedures which may result in dismissal shall notify the other of that fact [it would be useful to set out the relevant points of contact eg respective HR Directors] and shall discuss with the other the circumstances which have led it to contemplate initiating proceedings.

    b) the University and the Trust will co-operate with each other to facilitate any investigation into the alleged misconduct.

    c) the University and the Trust shall consider whether the case is such that both parties would have grounds for instituting disciplinary proceedings and, if that is the case, agree whether action is to be taken under each of their appropriate disciplinary procedures and the sequence in which those procedures shall be operated.

    d) any party considering restriction of practice or exclusion from work of the clinical academic shall advise the other of its proposal to restrict or suspend and discuss this prior to the clinical academic being so restricted or suspended, where it is practical to do so.

    e) the University and the Trust shall liaise with each other on the steps to be taken under the applicable disciplinary procedure or procedures, in particular as regards representation by both employers on any disciplinary panel established under any of their applicable procedures and the facilitation of the calling of witnesses and/or the

production of documentary evidence necessary for the purpose of determining whether misconduct has occurred.

f) the University and the Trust (as the case may be) shall keep the other informed of the progress and outcome of their respective procedures, including of any appeal.

11. While the University and the Trust shall co-operate with each other as described above, each acknowledges that the other has the ultimate right to determine whether or not disciplinary proceedings should be instigated, to determine whether misconduct has occurred and, if so, whether dismissal is the appropriate sanction to be applied on the facts of that case. Representation of the Trust on the University's disciplinary panels (and *vice versa*) does not mean that that the Trust's representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and *vice versa*).

Joint Appraisal

12. The University and the Trust shall agree procedures for the joint appraisal of members of clinical academic staff and ensure that such arrangements are referred to in the terms of the substantive and honorary contracts issued to the member of staff.

Dismissal on Performance, Absence or Ill-Health Grounds

13. In the event that either the Trust or the University considers that there are grounds for considering the dismissal of a member of clinical academic staff on the grounds of performance, absence or health grounds, each will advise the other of that fact [again it may be useful to specify the points of contact eg HR director] and shall discuss:

a) whether action is to be taken under the procedures of the University or the Trust or both (and if both, which procedure shall take priority);

b) whether it is appropriate to consider the restriction of practice or exclusion from work of the member of staff concerned in relation to either the academic or clinical duties or both. Any party considering restriction of practice or exclusion from work of the clinical academic member of staff shall advise the other if its proposal to restrict or exclude and discuss this prior to the clinical academic member of staff being restricted or excluded where it is practical to do so; and

c) (in cases of sickness absence, or medical incapacity) whether it is necessary to obtain a medical report from an Occupational Health adviser or from an independent medical expert on the ability of the employee to perform the duties of his/her employment. The University and the Trust shall discuss the questions/issues to be raised with such medical adviser, in particular any issues arising under the Disability Discrimination Act 1995, including any duty to make reasonable adjustments.

14. The University and the Trust shall keep each other advised of the actions taken under their applicable procedures, including the outcome of any appeal.

15. While the University and the Trust shall co-operate with each other as described above, each acknowledges that the other has the ultimate right, in relation to any matter being dealt with under its procedures, to determine whether or not to dismiss the member of staff concerned. Representation of the Trust on the University panel (and vice versa) does not mean that that representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and vice versa).

Dismissal on the grounds of redundancy or re-organisation

16. In the event that either the Trust or the University is contemplating the dismissal for redundancy or other re-organisational reasons of any member of clinical academic staff it shall advise the other of this fact and shall keep the other regularly informed of the action being taken in this respect.

Other general provisions regarding co-operation

17. The University and Trust shall ensure that:

    a) their respective procedures provide that, while either the University's or the Trust's disciplinary procedure is being applied to a member of clinical academic staff, that individual may not bring any complaint relating to those proceedings under the grievance procedure of the other employer (ie of the Trust or the University, as the case may be).

    b) rights of appeal will be confined solely to the procedure which is being implemented and individual employees may not appeal across procedures to the other party (ie the University or the Trust as the case may be).

    c) their contracts of employment and procedures are as far as possible sufficient to allow the disclosure of information from one to the other (in particular of personal data or sensitive personal data) under the Data Protection Act 1998, whether with or without the consent of the member of staff concerned. The Trust and the University will also discuss and agree guidelines for the disclosure of data regarding third parties, in particular data relating to patients.

18. The University and the Trust shall meet on a regular basis to review this Agreement and its operation.

This appendix has been drafted at the request of the Universities and Colleges Employers Association by Pinsents, solicitors, 1 Park Row, Leeds, LS1 5AB. In the event of any queries, please contact Chris Mordue, Partner Personal information redacted by USI or Personal information redacted by USI

The Regulation and Quality Improvement Authority

Review of Governance Arrangements in HSC Organisations that Support Professional Regulation

January 2017

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews aim to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. The majority of our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health, Social Services and Public Safety, and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting on four key stakeholder outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Are services well-led?

These stakeholder outcomes are aligned with Quality 2020[1], and define how RQIA intends to demonstrate its effectiveness and impact as a regulator.

The review was undertaken by Dr David Stewart (Reviews and Medical Director, RQIA), Dr Gareth Lewis (Clinical Leadership Fellow, RQIA), and Ronan Strain (Project Manager, RQIA).

RQIA thanks all those people who facilitated this review through participating in discussions, interviews, attending focus groups or providing relevant information. We would particularly like to thank the following HSC organisations and Professional Regulatory Bodies for providing information to underpin the review process:

- Health and Social Care Trusts (HSC Trusts)
- Health and Social Care Board (HSC Board)
- Public Health Agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- General Medical Council (GMC)
- Northern Ireland Social Care Council (NISCC)
- Northern Ireland Medical and Dental Training Agency (NIMDTA)
- Nursing and Midwifery Council (NMC)
- General Dental Council (GDC)
- Pharmaceutical Society Northern Ireland (The Society)

[1] Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland - http://www.dhsspsni.gov.uk/quality2020.pdf

Table of Contents

Executive Summary

As part of its 2015-18 review programme, RQIA conducted a review of Governance Arrangements in HSC Organisations that Support Professional Regulation. The review examined the clinical and social care governance arrangements to consider if they were in keeping with the standards and guidelines set by HSC Organisations and Professional Regulatory Bodies, in order to provide assurances to the Northern Ireland public that all health professionals are registered and fit to practise.

Individual professionals are personally accountable for their professional practice and must participate in the activities required to maintain their registration with their professional regulator. HSC Organisations need to ensure that the professionals they employ are supported, monitored and facilitated to meet the requirements of their professional regulators.

RQIA found that all eight HSC organisations involved in this review had robust governance arrangements in place, to ensure essential requirements for professional registration and regulation are adhered to.

Each organisation had effective generic processes in place in relation to:

- Annual checks to ensure that professionals adhere to their registration requirements
- Handling concerns and complaints about individual performance
- Annual appraisal processes and supervision

For individual professions RQIA found that:

- Arrangements for the revalidation of medical staff were now embedded
- Systems were in place to take forward nursing revalidation
- There were arrangements and systems to support the registration of the social care workforce, to include social care workers
- Pharmacists, dentists and bio-medical scientists function in well-regulated environments

RQIA was also provided with examples which demonstrated that HSC organisations understand the importance of professional registration and regulation of their workforce. Registration and regulation is now regarded as a core component of provision across all services, and is recognised to be valuable in the context of service change, increasing demands and expectations, and growing complexity of service users.

Chapter 1: Introduction

1.1 Introduction

The Department of Health in England white paper: *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, which was published in February 2007[2], sets out a programme of reform for the United Kingdom's system for regulation of health professionals.

In Northern Ireland, health and social care (HSC) organisations are responsible and accountable for assuring the safety, quality and availability of the services they commission and provide. Integral to this is effective leadership and clear lines of professional and organisational accountability, achieved through a robust governance framework.

Professional regulation systems, such as registration and revalidation, are a vital component of effective governance and management arrangements. Although these systems are the responsibility of the professional regulatory body, they should be complemented and mutually supported by the employing HSC organisation to assure the Northern Ireland public that all health professionals are registered and fit to practise.

To underpin these systems of professional regulation and to ensure the provision of high quality services, each HSC organisation needs robust systems of clinical governance and appraisal.

Enhancing and strengthening the process of appraisal requires clinical governance and quality improvement systems to function effectively in support. It is important for HSC organisations that appraisal operates effectively as an intrinsic part of their clinical governance and quality improvement systems.

Information requirements and arrangements for information sharing between these systems should be clear. Integration of these systems should help staff produce supporting information for their portfolio, where appropriate, but also enable performance concerns to be dealt with effectively, in a timely manner and not delayed until the appraisal discussion.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf

1.2 Context of the Review

During the RQIA consultation to develop a prioritised programme of thematic reviews for the period 2015-18, RQIA was requested to review the governance arrangements in HSC organisations that support professional regulation.

There are increasing demands placed on health and social care services in Northern Ireland due to an ageing population, high patient expectations, increasing prevalence of chronic conditions, advances in technology and therapeutics, and changes in the way services are delivered.

It is clear that professional staff in Northern Ireland have many challenges ahead. It is important that the people of Northern Ireland are assured that staff are fit to practise and HSC organisations have robust governance processes in place to continue to be safe and effective.

In November 2009, the General Medical Council (GMC) commenced the work on arrangements through which every doctor wishing to remain in active practice in the United Kingdom is required to hold a licence to practise, by undergoing a process of revalidation.

Revalidation largely draws on existing clinical governance systems and relies on each doctor collecting a portfolio of evidence over a five year cycle to comply with standards set out by the GMC. In June 2010, legislation enacted by the Northern Ireland Assembly required each body designated by the legislation to appoint a Responsible Officer (RO). The RO is responsible for ensuring that effective clinical governance arrangements are in place and for making a revalidation recommendation to the GMC, concerning doctors linked to their organisation.

Between 2008 and 2011, RQIA carried out the following reviews that concluded that these processes were well established with effective leadership.

- Review of Appraisal Arrangements Provided by NIMDTA for Primary Care
- Review of Readiness for Medical Revalidation in the HSC Trusts
- Review of Readiness for Revalidation in Primary Care in Northern Ireland

Clinical governance and quality improvement systems should be reviewed regularly to ensure they are fit for the purpose of supporting professional regulation.

As part of its 2015-18 review programme, RQIA has carried out this review, to gain assurance as to the effectiveness of the existing governance arrangements in HSC Organisations that Support Professional Regulation.

The RQIA review focused on the following professions employed by commissioners (HSC Board & PHA) and providers (HSC Trusts):

- Doctors
- Nurses & Midwives
- Social Workers & Social Care Workers
- Pharmacists & Pharmacy Technicians
- Community Dentists & Dental Care Professionals

The review also focused on the Northern Ireland Blood Transfusion Service (NIBTS). The NIBTS is an independent, Special Agency of the Department of Health (DoH). It is responsible for the collection, testing and distribution of over 64,000 blood donations each year. The Service operates three mobile units at around 250 locations throughout the province. The NIBTS employs a number of medical and nursing professionals, as well as a large cohort of biomedical scientists and laboratory assistants. Biomedical scientists are required to be registered and regulated to ensure they are fit to practise. The review team acknowledged that the NIBTS operates within a highly regulated environment; however, the review team felt it was important to include biomedical scientists and laboratory assistants employed by NIBTS in this review.

The review did not focus on the following health professionals as these professions have been reviewed by RQIA throughout 2015:

- Allied Health Professions (AHPs)
- Northern Ireland Ambulance Service (NIAS)
- General Practitioners (GPs)

1.3 Terms of Reference

The Terms of Reference of the Review:

1. Review the effectiveness of the governance arrangements in place within HSC organisations which underpin systems of professional regulation for the following professions:

    - Medicine
    - Nursing and Midwifery
    - Social Work (to include Social Care Workers)
    - Pharmacy (to include Pharmacy Technicians)
    - Community Dentistry (to include Dental Care Professionals)
    - Biomedical Science (NIBTS Only)

2. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvements if required.

1.4 Methodology

The review methodology was designed to gather information about current governance arrangements in HSC organisations (including those that Support Professional Regulation).

The methodology was as follows:

- Literature search/review to determine relevant areas in relation to clinical governance and professional regulation.

- Discussions with Professional Regulatory Bodies (GMC, NISCC, NMC, GDC, and the Pharmaceutical Society of Northern Ireland).

- Self-assessment questionnaire completed and returned by HSC Trusts, HSC Board, PHA, & the Northern Ireland Blood Transfusion Service.

- Formal Meetings with senior representatives from each HSC organisation's professional group.

- Focus groups with frontline staff.

- Regional Summit Event involving all relevant stakeholders, to present findings and draft recommendations.

- Publication of an overview report of the findings of the review.

Chapter 2: Findings

Findings from the review are presented in two sections:

1. Generic Governance Arrangements that Support Professional Regulation
2. Profession Specific Governance Arrangements that Support Professional Regulation

2.1 Generic Governance Arrangements that Support Professional Regulation

2.1.1 Registration

The review found that all HSC organisations have robust systems and processes in place, to ensure that employed professional staff adhere to their registration requirements on an annual basis. HSC organisations follow a Registration and Verification Policy which assures registration is addressed. The review also found that HSC organisations have policies for the employment of Locum and Agency Staff. For example, recruitment teams within each organisation carry out checks of professional registration and qualifications that are listed as essential criteria in job specifications. A copy of the applicant's qualification certificates and a print out from the professional body's website is also required and will be retained on their personnel file.

All HSC organisations maintain an alert letter database. This contains names of individuals who are under investigation, or who have been suspended or dismissed by an HSC employer, or who are considered by an employer to be a potential danger to the safety of patients, other staff or themselves. Recruitment teams check the alert letter database prior to forwarding a final offer to ensure that the applicant is not the subject of an alert.

All successful applicants are required to provide evidence of valid registration as part of normal pre-employment checks. Professional registration expiry dates are also recorded on the new HRPTS portal within HSC organisations, which are checked on a regular basis to ensure a registration has not lapsed.

HSC organisations are assisted by staff in the BSO Recruitment Shared Service Centre to subsequently check registration via the regulatory body's website checker, in order to confirm the applicant's registration remains valid on the date of the check.

Prior to any interview, the interview panel will review the application form to confirm live registration is in place and to discover whether the applicant has or has had any referrals to/investigations by the regulatory body. If it is noted that the applicant has declared any such issues, then the interview panel will explore this further with the applicant, at the end of the interview, having completed the normal assessment process. The panel will then decide if the

applicant is suitable for the post or not and will discuss how any issues relating to their practice can be accommodated in their role.

Following recruitment, staff will have their registration checked internally on a regular basis and reviewed at annual appraisal or supervision.

HSC organisations have mechanisms in place to check the status of staff by visiting online registers. For example, HSC Trusts are able to retrieve details for a number of staff at any one time, and be able to identify those medical staff who are:

1. registered with a licence to practise
2. registered without a licence to practise

In addition, HSC organisations have developed mechanisms to check staff registrations on a regular basis. Individual email reminders are also sent out to staff whose registration is due for renewal.

2.1.2 Handling Concerns and Complaints about an Individual's Performance

The review found that HSC organisations have effective internal and external processes and arrangements in place for handling concerns and complaints about individual performance. Where concerns are identified by a patient, service user or carer about the performance, conduct or competence of an individual staff member, the HSC Complaints Procedure[3] is used. Where concerns are identified regarding underperforming staff by other staff members, the organisation seeks to engage with the individual staff member to explore their presenting and underlying difficulties.

The review found that organisations follow the guidance of Maintaining High Professional Standards in the Modern NHS (MHPS)[4] framework in relation to specific concerns which are subsequently investigated following a defined procedure. Depending on the nature of the concern and the findings the organisation may then follow either disciplinary or capability procedures.

The capability procedure is used where there is evidence of a genuine lack of ability rather than a deliberate failure on the part of the employee to perform to standards of which he/she is capable. The aim of this procedure is to improve their performance through on-going monitoring and support.

The disciplinary procedure is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behaviour.

[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-complaints-standard-and-guidelines-for-resolution-and-learning-updated-february-2015.pdf
[4] http://www.ajustnhs.com/wp-content/uploads/2012/05/Dept-of-Health-Discipl-Appeal-2005.pdf

Organisations may also seek to engage external organisations such as the National Clinical Assessment Service (NCAS)[5] which contributes to patient safety by helping to resolve concerns about the professional practice of doctors, dentists and pharmacists.

The review found that HSC organisations have various other policies and procedures in place that complement their procedures for managing concerns/complaints such as:

- Policy & Procedure for reporting & management of incidents
- Policy for completing IR1 incident form (near miss & incident record form)
- Whistleblowing Policy
- Working Well Together Policy
- Management and Handling of Complaints
- Disciplinary and Competence policies and procedures
- Procedures for Initiating and responding to referrals to Professional Regulatory Bodies and Independent Safeguarding Authority
- Requesting DoH to issue an ALERT

Senior staff within trusts, in conjunction with their HR Employee and Engagement team will investigate concerns about an individual's conduct and the potential impact on their fitness to practise. If this is found to be impaired and the individual is dismissed from employment, the case is forwarded to senior management to consider referral to the appropriate regulatory body.

The review found that many concerns or complaints are dealt with effectively at the time they are discovered and not delayed until an appraisal discussion. A collaborative decision is taken whether to refer individual workers to their regulatory body, following disciplinary or capability procedures. Regulatory bodies are automatically informed when a worker is suspended from work pending disciplinary/investigation action.

There are a variety of potential outcomes depending on the severity of the level of under-performance; for example, retraining, supervision, disciplinary action, change of duties, referral to occupational health, or referral to the relevant regulatory body.

The Whistleblowing Policy also provides guidance for staff on how to report concerns of wrongdoing, malpractice or inadequacies in the provision of services, and should provide protection for those staff that raise concerns.

[5] http://www.ncas.nhs.uk/

2.1.3 Sharing Internal and External Complaints and Incidents

The review found that HSC organisations have systems and processes for the collation, investigation and management of comments, complaints, incidents, serious adverse incidents (SAIs) and litigation.

Any internal or external complaints or incidents will be reported and managed initially via the organisation's incident reporting and investigation process and the DATIX system records and supports the management of these processes. Learning reports and outputs of DATIX are used to support a variety of governance structures and learning activities. Clinical Leads and senior staff investigate incidents and identify actions and learning.

The review found that HSC Trusts have a Safer Recruitment and Employment Alert Notice System Procedure that sets out the arrangements within their trust for the processing and issuing of Alert Notices.

Where a registrant receives sanctions, or is suspended or erased from the professional register by a regulatory body following a complaint or incident, senior management contact the DoH requesting the issuing of an Alert Letter to external bodies. Where circumstances dictate, a referral may also be made to the Independent Safeguarding Authority.

External complaints from service users/carers regarding staff are dealt with under the Regional Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning (DHSSPS 2009)[6]. Learning and/or concerns from complaints can be escalated to Assistant Directors and Executive Directors if required. Senior management teams work in collaboration with other multidisciplinary teams to monitor complaints/incidents regarding trends, risks and potential escalation.

Learning is also shared through appropriate governance arrangements such as, Lessons Learnt Committees, Newsletters and Lessons of the Month initiatives. Serious Adverse Incidents are also reported to external organisations; for example, HSC Trusts report to the HSC Board/PHA in line with an agreed SAI process.

[6] https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/HSC%20Complaints%20%20Standard%20and%20Guidelines%20for%20Resolotion%20and%20Learning%20-%20Updated%20February%202015.pdf

2.2 Profession Specific Governance Arrangements that Support Professional Regulation

2.2.1 Medical Profession

Generic Governance Arrangements

In the organisations that were the focus of this review, the review team acknowledged that medical professionals work in well-established regulated environments. However, it can be a challenge for these organisations to ensure all medical professionals have a full understanding of the governance arrangements, systems and processes within the organisation in which they work. The review also found concerns in relation to the transfer of timely and accurate information when medical staff move between HSC organisations, especially in relation to an individual's professional performance, complaints, and incidents.

Appraisal, CPD and Revalidation

The review found that all HSC organisations have appraisal systems and processes in place to annually appraise their doctors, and check they are up to date and fit to practise. Annual appraisal is a contractual requirement, and is seen by an increasing majority of medical staff as an essential part of their profession, and an opportunity to "showcase" their work. Evidence from the review highlighted a shift away from viewing appraisal and revalidation as a "tick-box" exercise, towards a process in which a quality portfolio was used to provide evidence of good clinical work and professional development.

HSC organisations have developed a range of policies covering appraisal and revalidation, for example, 'Medical Appraisal & Revalidation Policy' which is designed to strengthen the link between appraisal and revalidation. Some HSC organisations also maintain a webpage dedicated to Medical Appraisal and Revalidation which is the primary source of all relevant publications (trust and regional) and includes a range of supporting documentation and templates.

Registered doctors are required to follow CPD recommendations of the various Royal Colleges, for example, completion of 50 hours CPD per year, 25 hours of which must be externally accredited.

RQIA is aware that doctors typically have time set aside for non-clinical activity, however, during focus groups, some doctors highlighted difficulties with meeting their CPD requirements, within their allocated Supporting Professional Activity allowance and would welcome more protected CPD time within work.

Appraisal rates for 2013-14 and 2014-15 in HSC organisations ranged from 71% to 100% for all eligible medical staff.

Recommendation 1	Priority 2
RQIA recommends that HSC Trusts report profession-specific appraisal rates for all eligible professional staff in their Annual Quality Report.	

Revalidation was introduced in December 2012 and required all licensed doctors to demonstrate on a regular basis that they are up to date, fit to practise in their chosen field, and able to provide a good level of care. Licensed doctors have to revalidate every five years and this is supported by having annual appraisals based on the core guidance for doctors, *Good medical practice*[7]. Annual appraisal, in addition to being a contractual requirement, is a pre-requisite to securing a positive recommendation for revalidation. The review found that some HSC organisations have established dedicated revalidation support teams or departments to assure that doctors continue to meet the professional standards set by the GMC and the relevant Royal Colleges. Senior administrative/managerial support was felt by some HSC organisations to be essential in supporting delivery of medical revalidation locally.

To strengthen the appraisal process, HSC organisations have identified a number of Medical Appraisers who are required to undergo specific training. In addition, some HSC organisations have produced the following in an effort to deliver consistency:

- Appraiser and appraisee handbooks
- Good Practice Guidance for Completion of Clinical Appraisal Form 3 and PDP's
- A standardised 'Template for Assessing the Quality of Evidence for Appraisal and Revalidation'

These arrangements provide assurance for the public and patients that medical staff are supported in maintaining high professional standards in the workplace.

The review did find variances across HSC organisations in relation to electronic and paper based appraisal and revalidation portfolios. The majority of organisations would welcome a centralised electronic version, however, there does need to be a balance with face-to-face contact and the option of using paper and pen for some appraisers.

The review found that appraisal is an individual organisational activity, however, systems and processes are not standardised across organisations.

The review found that the Western HSC Trust has been working on developing revalidation systems, the utility of which could be explored by other HSC trusts/relevant HSC bodies.

[7] http://www.gmc.uk.org/The_Good_medical_practice_framework_for_appraisal_and_revalidation___DC5707.pdf_56235089.pdf

Support, Education & Learning

The review found that HSC organisations have varied systems and processes in place for educational governance and leadership to manage and deliver education, training, and CPD opportunities for their medical staff. Some have developed a number of initiatives and good practice which include:

- A Learning and Development Agreement for the provision of postgraduate medical training and education with NIMDTA. This agreement sets out the systems of education governance and leadership to manage and deliver education training and CPD opportunities for medical staff.
- Dedicated websites for doctors for all information pertaining to appraisal and revalidation, medical training and medical induction.
- Specific departmental induction programmes for each division, with a number of core mandatory training modules that doctors must complete as a condition of commencing employment.
- Induction meetings with the Medical Director for each new permanent medical member of staff. At this meeting initiatives such as Medical Leadership and Development programmes and Mentoring Schemes are highlighted.
- HSC Trusts operate an Appraisal Induction Scheme for all new starts, which encourages early development of a Personal Development Plan (PDP).
- Morbidity and Mortality (M&M) review meetings are also a core educational component for doctors. Work is ongoing in some trusts to support a regular M&M meeting for all doctors.
- Review of Complaints/Incidents/ SAIs. SAIs are screened by Associate Medical Directors and regional learning is shared in the form of 'learning letters' that are circulated by the HSC Board and PHA to all medical staff.
- Regular lunchtime Staff Grade and Associate Specialist (SAS) doctors' Link-Up sessions which are held across the trusts.
- In-house Medical Leadership and Development events.
- A standard process for applying for study leave and funding for doctors in training.
- Planned audit and review of all doctors' PDPs as part of an appraisal round.
- Departmental learning events for doctor's e.g. weekly journal clubs etc.

HSC organisations welcome the presence of a local GMC office in Northern Ireland and they have also developed close links with the GMC Employment Liaison Adviser. Organisations regularly engage with the GMC for guidance, support and to discuss cases of concern, fitness to practise thresholds, registration queries and to seek advice in individual circumstances.

The role of the GMC Liaison Adviser in Northern Ireland is to engage with medical staff in trusts, doctors in training and those who are new to United Kingdom practice. They provide practical support and targeted discussion around GMC standards, guidance and reviews.

The review team heard the experience of one doctor who was returning to work after raising a family. They faced a potentially complex journey to becoming reinstated on the medical register, being employed by a trust, and having to provide supporting documentation for a first appraisal. This doctor described a very positive experience from the initial support provided, through to an identity check with the GMC in Manchester and providing evidence of her CPD via a GMC smartphone application. The review team was impressed with the smoothness of the transitions between professional and regulatory governance arrangements and structures. The doctor was assured by these processes that she was both fit to practise and had clear evidence to support this.

2.2.2 Nursing and Midwifery Profession

Readiness for Revalidation

Revalidation for all nurses and midwives in the United Kingdom began to be compulsory from April 2016. In addition to demonstrating nurses' and midwives' ability to practise safely and effectively it is designed to encourage reflection upon, and living out the standards contained within the NMC Code[8].

This new process replaces the old post-registration education and practice (Prep) requirements. Nurses and midwives will have to revalidate every three years to renew their registration.

The review team was provided with evidence that relevant HSC organisations have put significant arrangements in place to become ready for NMC revalidation. These included:

- Base line assessments to identify current registrants e.g. Midwives, Nurses, Bank Only Nurses, and Bank Only Midwives
- Supporting and engaging nurses and midwives to assist understanding and application of the NMC's revised Code
- Scoping individual and managerial readiness to ensure timely revalidation
- Information and Awareness sessions delivered by NIPEC and NMC
- Development and implementation of guidance on collating feedback from patients and colleagues
- Supporting confirmers and third-party appraisers in their roles and ensuring they understand their responsibilities
- Supporting managers to put in place systems to facilitate discussions and confirmer meetings ensuring they understand their responsibilities
- Developing methods of assurance on consistency in confirmers'/ third-party appraisers' judgements
- Engaging with training providers, e.g. the Clinical Education Centre (CEC), to support revalidation learning and compliance activities
- Revalidation Implementation Groups will support implementation of the new arrangements across the directorates
- Ongoing development of a bespoke database to monitor revalidation status across the organisation (HRPTS functionality to capture high level nursing revalidation information was under development at the time of fieldwork)
- Monthly reporting to identify those whose annual fee and revalidation is due
- Communication strategies to alert registrants to the additional requirements and timescale for revalidation
- A Regional Revalidation Programme Board, Co-Chaired by the CNO and Director of Human Resources (DoH)

[8] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

The review found that nursing and midwifery teams are becoming increasingly multidisciplinary, with collaborative working across specialities. For example, nurses working in multidisciplinary teams where the management is not nursing or midwifery led. The NMC revalidation process is registrant led and individual registrants are responsible for their own revalidation. However, significant work has been undertaken by HSC Trusts in order to support registrants to meet revalidation requirements. With regard to nurses working in primary care, the review team would also like to acknowledge the work of NIPEC and the PHA who undertook a programme of intensive work to communicate with and support practice nurses attached to GP practices with revalidation requirements.

During preparations for the introduction of NMC revalidation, significant steps were taken to ensure organisations representing all groups were informed and reminded of their responsibilities regarding the cascade of information.

Appraisal, Knowledge and Skills Framework (KSF) and Supervision

The review found that all HSC organisations have processes and systems in place for annual appraisal of all nursing and midwifery staff. Arrangements under Agenda for Change and the HSC KSF/Appraisal Policy require that all NMC registrants have a yearly appraisal meeting with their line manager. The standardised documentation which supports this process has been adapted to incorporate the NMC Code.

In 2007, the Chief Nursing Officer (CNO) for Northern Ireland published 'Standards for Supervision in Nursing' which requires nurse registrants to undertake a clinical supervision meeting with their line manager twice per year[9]. At the time of this review midwives were subject to the separate process of Statutory Supervision of Midwives through the Local Supervising Authority (LSA) in Northern Ireland (the Public Health Agency). The standards for supervision of midwives are set and monitored through the 'Midwives rules and standards' (NMC 2012). The LSA reports annually on supervision, and is audited by the NMC. Statutory supervision of midwives by the NMC is currently under review by government and will soon be subject to legislative change'.

Every three years, nurses and midwives need to revalidate in order to renew their registration. From April 2016, revalidation includes requirements in the previous three years for at least 450 practice hours and 35 hours of CPD, at least 20 of which must include participatory learning.

Feedback from frontline staff highlighted that supervision and annual appraisal are seen as a core component of their work, and contribute to high quality, effective and efficient revalidation every three years. Annual appraisal is a contractual requirement, while supervision is a standard set by the profession.

[9] http://www.nipec.hscni.net/work-and-projects/previousworkandprojects/supervision-standards-for-nursing-project/supervisionstandardsnursing-docs/

Support, Education & Learning

HSC organisations provide Nursing and Midwifery induction programmes three times per year for all new nursing and midwifery staff. As part of pre and post registration, all new nursing and midwifery staff undertake induction education programmes in medication management to meet NMC requirements.

During and following completion of their preceptorship period, nursing staff must complete an Intravenous Drug Administration course which is supported by a competency framework tool. All registered nursing staff update their training on administration of medicines on a three-yearly basis, as a mandatory requirement set by HSC Trusts.

The review also found that all HSC organisations have systems of educational governance and leadership to manage and deliver education, training, and KSF/CPD opportunities for registered nursing and midwifery staff. Education, training and CPD opportunities are managed in a variety of ways:

1. CPD opportunities are identified through the process of annual appraisal.
2. In house mandatory training is managed and delivered by the organisation using face to face and e-Learning methodologies.
3. Dedicated training teams manage targeted training e.g. Mentorship, Infection Control.
4. A Service Level agreement with the Clinical Education Centre (CEC) permits access to a variety of training courses; HSC organisations also engage with the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC).

The review highlighted that efforts are made to commission training for individual staff members, when requirements within their scope of practice have been identified at annual appraisal.

All registered nurses and midwifes are assigned to a senior member of the nursing/midwifery teams for induction, supervision, facilitation and critical companionship. On commencement of employment, each nurse/midwife is issued with an induction folder which contains a comprehensive training matrix.

2.2.3 Social Work Profession

Registration of the Social Care Workforce

The review found that HSC organisations welcomed the DoH decision to introduce compulsory registration of the whole social care workforce on a phased basis. Social workers have been required to register with the NISCC since 2005 and there has been a programme of roll out to 30,000 social care workers since 2009. It is anticipated the final groups of social care workers will be registered with the NISCC by March 2017. RQIA was informed that there is a differentiated approach to the registration and regulation of social workers and social care workers reflecting the differences in qualifications, training, levels of autonomy, responsibility, employment patterns and salary level with domiciliary care workers among the lowest paid within the social care family.

Whilst the review examined governance arrangements solely within HSC, the review team acknowledged that approximately two thirds of the social care workforce is employed in the independent sector (i.e. the voluntary and private sectors). The review team was provided with evidence that the roll out of compulsory registration has been to all social workers and social care workers irrespective of sector. Roll out of compulsory registration to social care workers has been on the basis of 'employed within prescribed settings', all of which are services regulated by RQIA.

Appraisal, Knowledge and Skills Framework (KSF) and Supervision

Annual appraisal for social care staff is undertaken through the Knowledge and Skills Framework (KSF), and a Personal Development Plan (PDP) is developed which addresses the particular needs of employees. All social work staff are expected to adhere to the DoH policy and standards for professional supervision of social workers. HSC organisations also have their own policies/procedures for supervision of social care workers in line with Minimum Care Standards for regulated settings[10].

Social workers and managers of social care settings are required to re-register every three years. All other social care workers are required to re-register every five years. All registrants are required to complete 90 hours of post registration training and learning within each registration period.

HSC Trusts are required to report to the HSC Board on the provision of professional supervision for social workers as part of Delegated Statutory Functions reporting and accountability arrangements. HSC Trusts also have arrangements in place for the completion of the Person-Centred Planning (PCP) and PDP processes. For example, individual Directorate Performance Scorecards incorporate data on PCP/PDP performance.

[10] https://www.health-ni.gov.uk/articles/care-standards

Directorate Accountability Reviews address Directorate scorecard returns including PCP/PDP completion.

HSC Organisations operate an appraisal and supervision policy for social workers in line with the DoH policy and standards for professional supervision of social workers. HSC organisations also have their own internal policy/procedures on supervision for social care workers in line with Minimum Care standards of regulated social care settings and what is required.

RQIA found a strong culture of supervision within social work. For all professionally qualified social workers this takes place on a monthly basis in a one to one session; however, for social care workers a mixed approach to supervision exists.

The Improving and Safeguarding Social Wellbeing: A Strategy for Social Work[11] sets out an agenda to strengthen the effectiveness of social work in improving outcomes for service users. One of the priorities of the Strategy is to ensure that professional governance arrangements, including professional supervision, support social workers to work to consistently high standards and manage risks effectively

Support, Education & Learning

The review found that HSC organisations have systems of governance and leadership to manage and deliver education, training, and CPD opportunities for Social Workers and Social Care Workers. For example, HSC trusts have dedicated Social Services Workforce Development and Training Teams which deliver the Personal Social Services Education and Training Strategy'[12], which provides a framework for education, training and continuous professional development opportunities.

Under the Scheme of Delegation for Statutory Functions, HSC trusts are required to maintain the training standards of their social care workforce, and to continue to address and meet strategic objectives and targets for training as set out by the DoH in Circular HSS (OSS) 1/2010 & 3/2012, and in the NISCC: "General Guidance Document for social work registrants and PRTL Requirements"[13].

The Post Qualifying framework, now renamed Professional in Practice (PiP)[14] Framework for Social Work Professional Development, supports social workers to comply with post-registration requirements and to gain recognition of their learning throughout their careers against a set of professional standards. For the vocational workforce, some HSC trusts have developed a Qualification and Credit Framework (QCF) Strategy 2015.

[11] http://www.niscc.info/storage/resources/2012april_dhssps_socialworkstrategy2012-2022_afmck1.pdf
[12] http://www.niscc.info/files/Workforce%20Development/2006_PSS_TrainingStrategy.pdf
[13] http://www.niscc.info/files/2012Jun_PRTLGuidanceforSocialWorkers.pdf
[14] http://www.niscc.info/files/PiP/Stepped_Booklet_web.pdf

The review found that there has been significant progress in areas such as the Domiciliary Care workforce with significant numbers of staff achieving the Level 2 award in End of Life Care. These frameworks ensure that staff are developed and practising in line with national occupational standards (NOS)[15].

The review also found that HSC Trusts target training towards particular groups, based on monitoring of adherence to strategic targets, which are reported on an annual basis to the HSC Board. HSC Trusts use this information to target training at particular groups to ensure that resources are being used effectively. The HSC Trusts have also developed a Post Qualifying Policy for social workers only, which specifies the roles and responsibilities of staff, line managers and training teams.

The review team was informed that the Circular HSS (OSS) AYE 2/2015[16] (Assessed Year of Employment of Newly Qualified Social Workers) states 'All newly qualified social workers should be clearly identified as such in the Human Resources information system in order that individuals can be tracked through to successful completion (of their AYE)'. There are also references to supervision, induction, professional development and performance appraisal of newly qualified social workers in this Circular.

[15] http://nos.ukces.org.uk/Pages/results.aspx?u=http%3A%2F%2Fnos%2Eukces%2Eorg%2Euk&k=Social%20Work
[16] http://www.niscc.info/storage/resources/2015_dhssps_aye_circular.pdf

2.2.4 Pharmacy Profession

Generic Governance Arrangements

In the organisations that were the focus of this review, the review team acknowledged that pharmacy professionals work in well-established regulated environments. Governance arrangements, systems and process are embedded within the pharmacy culture, and are seen as a core part of their functions.

Future Registration and Regulation of Pharmacy Technicians

Within Northern Ireland, pharmacy technicians are not required to register with the Pharmaceutical Society Northern Ireland (the Society) which is the regulatory body for pharmacists in Northern Ireland. In the rest of the United Kingdom technicians are required to register with the General Pharmaceutical Council (GPhC). The review found that both pharmacists and pharmacy technicians would welcome registration and regulation as it would recognise technicians as professional members of the pharmacy team. It would also provide a number of benefits for the technician, pharmacist and most importantly, service users.

Registration of technicians will contribute to improved patient safety by ensuring only those qualified, competent and under a duty to maintain high standards can work as pharmacy technicians. For example, it will allow technicians to up-skill in order to take on greater responsibilities and work within a structured career pathway. It will also allow pharmacists to delegate roles without fear of legal sanction and release time for pharmacists to deal with more patient facing activities. This may have an additional impact in reducing pressures on other parts of the health service. The review team was informed that a public consultation closed on 14 June 2016 in relation to the future functions of the Society. This included consideration of the registration and regulation of pharmacy technicians.

The DoH continues to take a considered approach to the issue of regulating pharmacy technicians in Northern Ireland. RQIA was informed that there will be a process of consultation and legislative change before any decisions to statutory regulate technicians is progressed.

Appraisal, KSF and Continuing Fitness to Practise

The review found that HSC organisations have systems and clinical governance processes in place to support their pharmacy staff with their KSF/appraisal and continuing fitness to practise requirements.

Registered pharmacists are required to complete 30 hours of CPD annually to maintain their registration with the Society. Pharmacists in the hospital service would welcome protected CPD time within work, rather than having to complete 30 hours in their own time.

For pharmacists, confirmation that CPD has been completed, submitted and passed is obtained during an annual appraisal to ensure continuing fitness to practise, as stipulated in the Society requirements. The Society publishes a list of pharmacists removed from its register and this list is checked against pharmacy staff employed by the organisation by pharmacy administration staff. Administration staff also check the register on a regular basis to ensure that all pharmacists are registered. Pharmacists are encouraged to avail of learning and development opportunities offered by both their organisation and the Northern Ireland Centre for Pharmacy Postgraduate Learning and Development (NICPLD).

The review team was provided with instances were pharmacists present a subject from their area of expertise at monthly clinical pharmacy meetings, which provides a CPD opportunity for colleagues. Occasionally a member of the trust consultant staff may also present at such a meeting, on a topic of interest to those attending.

As pharmacy technicians are not registrants, they are not required to complete a specific amount of annual CPD; however, within trusts, technicians are encouraged to avail of learning and development opportunities offered by the trust or by NICPLD. Whilst NICPLD workshops are no longer available for technicians they are encouraged to complete distance learning packages available to them.

Rebalancing Legislation & Consultation on the Future Functions of the Pharmaceutical Society Northern Ireland

A possible outcome of existing legislation is that a pharmacist may face criminal prosecution for a single dispensing error. This has long been a concern for pharmacists within Northern Ireland, and could also impact on future registered pharmacy technicians. Removing this barrier will help encourage a more open approach to error and near miss reporting, improve learning and promote a more transparent culture with ultimate benefits for patient safety.

The government is proposing a new defence against criminal prosecution for pharmacy professionals if they make an inadvertent dispensing error, subject to certain conditions. As a result, in February 2015, the Government launched a Consultation regarding the Rebalancing Medicines Legislation & Pharmacy Regulation[17], and sees the proposals set out in the consultation as a positive step towards a modern approach to healthcare regulation. The review team was informed that the DoH is already prioritising and progressing this work with regard to Northern Ireland.

During the review concerns were raised that having both the GPhC and the Society as regulators of a single professional body results in inconsistencies in approach. It also means that a pharmacist moving between jurisdictions

[17] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403387/consultation_doc.pdf

has to register with another entity and that any pharmacist working in both jurisdictions requires dual registration. The possibility of having a single pharmaceutical regulator for the whole of United Kingdom was welcomed.

2.2.5 Dental Profession

The review team acknowledged that the dental profession works in well-established regulated environments. Governance arrangements, systems and processes are embedded within the dental culture, and are seen as a core part of their functions. Both dentists and dental care professionals are required to register with the GDC. RQIA was advised that the registration of dental care professionals was viewed very positively by the profession.

Governance Arrangements and Structure of Community Dental Services

Within Northern Ireland there are two major branches of the dental profession (general dental practitioners sit outside the trust structures as independent practitioners):

1. Hospital Consultant Dental Service – based at the School of Dentistry (Royal Victoria Hospital, Belfast), Ulster Hospital (Dundonald), and Altnagelvin Hospital.

2. Community Dental Service – based at Health Centres and Health and Well-being centres across Northern Ireland.

In December 2014, RQIA published a report of a review of the Implementation of the Dental Hospital Inquiry Action Plan. That review assessed progress against the 45 recommendations contained in a report of an inquiry chaired by Mr Brian Fee QC. The action plan included many aspects that were to be assessed by this review of governance arrangements to support professional regulation and the review team considered that in light of this, it would not be necessary to include the School of Dentistry in this review.

The majority of Oral and Maxillofacial services in the Ulster and Altnagelvin Hospitals are provided by consultant staff who are both dentally and medically qualified. Although there are a number of singly qualified practitioners, the review team considered that the main issues for these services would be covered by the medical section of the report. This section of the review therefore concentrates on the community dental service provided by HSC Trusts.

Appraisal and Continued Professional Development (CPD)

The review found that all HSC organisations have systems of appraisal and clinical governance within their organisation. CDS Dentists undergo annual appraisal using a Regional Community Dental Service Appraisal Document in Northern Ireland. HSC organisations also ensure mandatory training is completed in line with organisational requirements.

Registered dentists are required to complete 250 hours of CPD every five years. At least 75 of these hours need to be 'verifiable' CPD. Dental Care Professionals must carry out at least 150 hours of CPD every five years. At least 50 of these hours need to be 'verifiable' CPD. CPD hours may be completed within working hours in HSC Trusts, especially for DCPs. Much of dentists' CPD is carried out in their own time. Dentists and DCPs would welcome protected CPD time within work, rather than having to complete these hours in their own time.

In addition, dentists in the CDS are funded to attend 21 study days over three years; however, as there is no funding for backfill, dentists find it difficult to attend. Study leave is granted to attend CPD appropriate to their job role. CPD attainment is checked during the appraisal process. Dental Care Professionals also undergo annual appraisal through the KSF framework.

Registered dentists and dental care professionals have a responsibility as individuals to maintain their own CPD. Dentists and DCPs make an annual self-declaration that they comply with CPD requirements as part of registration with the GDC.

2.2.6 Biomedical Science Profession

Governance Arrangements and Structure of Biomedical Medical Science

During this review, RQIA visited the Northern Ireland Blood Transfusion Service (NIBTS). The NIBTS is an independent agency which employs a number of biomedical scientists, Medical Laboratory Assistants and Laboratory Assistants.

The review team acknowledged that biomedical scientists and laboratory assistants within Northern Ireland work in well-established regulated environments, and are registered, regulated and inspected by a number of organisations such as, the Health and Care Professions Council (HCPC), The Medicines and Healthcare products Regulatory Agency (MHRA), and The Institute of Biomedical Science (IBMS).

Appraisal and Continued Professional Development (CPD)

The review found that the appraisal process within the NIBTS for biomedical scientists is organised and guided by their HR department, in line with the KSF framework.

Biomedical scientists are required to renew their registration every two years; in order to do this they must prove they have fulfilled the HCPC CPD requirements. These requirements are set out in a series of guidelines to improve professional development and patient care; however, no specific number of hours or course requirements are stipulated. Registrants are expected to keep a record of their own CPD and this is monitored through an HCPC audit of a random selection.

The review team was informed that the IBMS runs a similar system to the CPD scheme for biomedical scientists. They must achieve 250 CPD credits within five years. These credits are not based on hours; they are achieved by completing a variety of activities, each worth a certain number of credits, such as, attending a lunchtime seminar, giving a lecture/presentation to students or attending a conference. Once 250 credits have been achieved, the biomedical scientists will then submit an application for CPD validation to the IBMS, and achieve a diploma. The review team was informed that this is how the current scheme operates; however, the IBMS is moving to a new CPD scheme in summer 2016[18]. The IBMS CPD scheme encourages members to maintain, improve and extend their knowledge, skills and practice for the purpose of maintaining CPD.

Each biomedical scientist within the NIBTS undergoes an annual appraisal in the form of a 'Staff Development Review' (SDR) with their line manager. During this review, staff discuss training and/or CPD requirements they may have. Following this, a Personal Development Plan (PDP) is developed for each individual. On completion of departmental SDRs a Team Development Plan is then formulated, and these are used to complete a Corporate Training Needs Analysis.

During the SDR, staff may also add further personal objectives, for example, post entry qualifications, attendance at specific courses and conferences or participation in user groups, all of which will contribute to their CPD activities. Bi-monthly departmental meetings are held which also provide staff with a forum to discuss and share any CPD activities, concerns or suggestions.

The review also found that the NIBTS has the following recognised supervisors/trainers who deliver education, training and complete annual appraisal reports for individual biomedical scientists:

- A dedicated Laboratory Training Officer
- Two qualified IBMS Registration Portfolio verifiers
- Four University of Ulster trained mentors for placement students
- All HCPC registered staff will supervise training of trainee biomedical scientists and placement students to varying degrees depending on their job role.
- Annual appraisals for biomedical scientists and medical laboratory assistants are carried out by their line-manager, Deputy Head, or Head of Department depending on grade of staff.

[18] https://www.ibms.org/go/practice-development/cpd

Education and Learning

The review found that the NIBTS has systems and processes in place to manage and deliver education, training and learning opportunities for biomedical scientists.

The educational processes for laboratory staff take the form of on-going continuous improvement. This is led by the laboratory training officer and includes a programme of lunchtime seminars, mentoring for university placement students and a three yearly Quality Systems training programme, overseen by the Regulatory Affairs & Compliance department. In addition to this, all staff participate in their own individual CPD activities.

The Laboratory Manager is responsible for the management and professional development of all departmental staff. The Laboratory Manager delegates this role to the laboratory training officer and in cooperation with the laboratory training officer, will develop effective programmes of training for all laboratory staff and placement students.

The laboratory training officer develops induction programmes for all new members of staff and placement students and prepares a training plan for each member of staff/placement student. Each Department Head is responsible for delivery of training within his/her department and must ensure that training of biomedical scientists is delivered by HCPC registered staff.

NIBTS has been approved by IBMS as a training laboratory for pre & post registration Biomedical Scientists, and has the following systems and processes in place:

- Laboratory Training and Competency Policy
- Laboratory Training and Competency Procedure
- Corporate Induction Manual
- Laboratory Training Programme

Biomedical scientists have a responsibility to maintain a portfolio of Continuous Professional Development (CPD) in line with the requirements of the HCPC. This is subject to periodic review by the HCPC. In line with the 'Policy and Procedure for the Maintenance of Professional Registration', each biomedical scientist has a responsibility to ensure that HCPC registration is maintained.

Chapter 3: Conclusions

During this review, RQIA found robust clinical and social care governance arrangements within HSC organisations that support professional regulation. Organisations adhere to the requirements, standards and guidelines set internally and by Professional Regulatory Bodies to assure services users, carers and families that professional staff employed are fully fit to practise.

The review found that all eight HSC organisations involved in this review function in well-established regulated environments, with robust governance arrangements in place to assure essential requirements for registration and regulation are adhered to.

RQIA found that HSC organisations have engaged effectively with professional regulatory bodies such as the GMC, NISCC, NMC, GDC, The Society, and HCPC. Good links have been established to ensure continued registration of staff and HSC organisations are now informed in a timely manner of changes in guidelines. There is now effective joint working when dealing with concerns regarding underperforming staff and effective support is provided by regulatory bodies where appropriate. Some regulatory bodies however are perceived by staff to be more successful than others by virtue of local presence, provision of local engagement opportunities and provision of readily available professional guidance support and are perceived to provide better value for the annual retention fee paid.

RQIA was advised that a number of national and local initiatives are currently underway, for example, the intended UK-wide government consultation to explore reform of healthcare professional regulation. This will consider development of a national framework to assess which professional groups should be regulated and how. It is anticipated that the future direction of professions subject to professional regulation will be impacted by these initiatives. The review team considers that this needs to be accounted for during any review that takes place.

RQIA found strong commitment among HSC organisations to take forward professional registration and regulation of their workforce in Northern Ireland. This is an important element in providing assurance to the general public that the HSC workforce is fit for purpose and will continue to provide a high standard of care.

Appendix 1: Abbreviations Used

AHP	Allied Health Profession
AYE	Assessed Year in Employment
Belfast Trust	Belfast Health and Social Care Trust
BSO	Business Service Organisation
CDS	Community Dental Service
CEC	Clinical Education Centre
CNO	Chief Nursing Officer
CoDEG	Competency Development and Evaluation Group
CPD	Continuing professional development
DATIX	Healthcare Incidents, Patient Safety & Risk Management Software
DCP	Dental Care Professional
DoH	Department of Health, Northern Ireland
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
GPhC	General Pharmaceutical Council
HCPC	Health and Care Professions Council
HR	Human Resource
HRPTS	Human Resources, Payroll, Travel and Subsistence System
HSC	Health and Social Care
HSC Board	Health and Social Care Board
HSC Trusts	Health and Social Care Trusts
IELTS	International English Language Testing System
LD	Learning Disability
LTO	Laboratory Training Officer
MH	Mental Health
MHRA	Medicines and Healthcare Products Regulatory Agency
MLA	Medical Laboratory Assistant
M&M	Morbidity and Mortality
NCAS	National Clinical Assessment Service
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
NIBTS	Northern Ireland Blood Transfusion Service
NIMDTA	Northern Ireland Medical and Dental Training Agency
NIPEC	Northern Ireland Practice and Education Council
NISCC	Northern Ireland Social Care Council
NMC	Nursing and Midwifery council
NOS	National Occupational Standards
Northern Trust	Northern Health and Social Care Trust
NVQ	National Vocational Qualification
OCN	Open College Network
PALs	Procurement and Logistics Service
PDP	Personal Development Plan
PHA	Public Health Agency
PIP	Professional in Practice

Prep	Post-registration education and practice
PRTL	Post registration training and learning
The Society	Pharmaceutical Society Northern Ireland
QCF	Qualification and Credit Framework
QUB	Queens University
RO	Responsible Officer
RPS	Royal Pharmaceutical Society
RSSRS	Regional Shared Services Recruitment
SAI	Serious Adverse Incident
SBAR	Situation, Background, Assessment and Recommendation
SDR	Staff Development Review
SLA	Service Level Agreement
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
SCD	Special Care Dentistry
TOR	Terms of Reference
UUJ	University of Ulster
Western Trust	Western Health and Social Care Trust

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Assurance, Challenge and Improvement in Health and Social Care

Item	Attachment
Urology Update Papers for 12 to run through	 2. SHSCT update for DOH Urology Assura  Appendix 1 - Terms of Reference CLINIC/
Appraisal, Revalidation and Annual Management Reviews for Doctors Update on the discussion with UHB – potential for Annual Management Reviews to complement A&R processes	 MNOTES - 15 12 2020 11 30am UHB A
Individual Performance Review Shane to discuss what will be required for IPR re Medical Director	 FW IPR's.msg
Hyponatraemia Revised terms of reference for Hyponatraemia and proposed 8B job – also lead directorate	 Hyponatraemia Oversight - Updated
Judicial Review Correspondence from DLS re surgical patient – potential for future actions	 FW URGENT FURTHER Litigation M
MLA Queries Currently the Trust has a 10 day response time set. This is from Mairead McAlindens time to improve MLA relationships. The rest of the regional Trusts have a 20 day response time Volumes now make this challenging (30 received in a single day alone) can this be realigned with the region – comms to be issued regarding this	
Independent Medical Examiner	 RE Indepdendent Medical Examiner.msg
?? Colorectal Surgery	

Southern Health and Social Care Trust

Update to DOH Urology Assurance Group 18 December 2020

(Progress/updates from 12-18 December 2020)

Serious Adverse Incidents (SAI) Update (9)

Mid report of early identification of learning was shared with HSCB on 17 December 2020 and full reports x 10 (9 + 1 overarching) due end January 2021.

Summary of Activity for Patient Facing Information Line (17/12/20)

Calls up to 17th December 2020

- 144 calls to information line. (increase of 11 calls from last week)
- 8 email to the inquiry email address (increase of 2 emails from last week)
- 1 inquiry via complaints team (no more received since last week)
- 3 GP calls (one of these related to a private patient and medication – already escalated) (same as last week)
- 21 patients who have either contacted the information line/come via MLA/MP enquiry or from the GP query have been seen at clinic to date one of these patients need to be further investigate (same as last week – as Mr Haynes has been operating this week and no capacity for additional clinics)

Professor Sethia, Urology Subject Matter Expertise has agreed to look at all the patients that have contacted the Information Line and determine whether can advise them that they are not part of the Inquiry or whether they need to be follow-up. As this will take some time an acknowledgement letter is being sent out to all the patients/relative who have phoned in advising them that their case is being looked into and that they will be contacted as soon as the review is complete.

Independent Sector Clinics

- **194 management plans** have been received back from Independent Sector
  - **121** of these have been referred back to the care of their GP
  - **32** have been sent back to Trust for further care/follow-up.
  - **38** to be reviewed at Trust's Urology MDT (Professor Sethia has agreed to be the independent Consultant on these MDT's and these are commencing

on 14 January and will be every fortnight, and he has agreed to start reviewing the cases over the Christmas holidays).

- **3** referral to Oncologist for Urgent reassessment of treatment

Royal College of Surgeons Invited Review Service

Draft Terms of Reference has been drawn up for the Invited Review Service by the RCS – for agreement, tabled at HSCB meeting on 17th and attached as appendix 1.

General Medical Council

On the 15th December the GMC interim orders panel suspended Mr O'Brien from the medical register for a period of 18 months.

Structured Judgement Review (SJR)

The Trust met last week with the Royal College of Physicians to discuss the use of SJR methodology to support patient reviews. The Royal College of Physicians were supportive and felt it was an appropriate framework to use to conduct the described patient safety reviews in the absence of a full SAI process. The Trust is agreeing a core virtual training programme with the Royal College of Physicians team for a core group of reviewers.

Consultant's Private Practice

Internal Audit has commenced a review of Mr O'Brien's patients transferring into SHSCT as HSC patients. The review will also consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Staff Engagement

Recognising the 'second victims' in this process, the Trust continues to work at ways to ensure all staff involved are and will be supported through this process. Fortnightly Team meetings are continuing with the Clinical Teams and the Chief Executive, Medical Director and Director of Acute Services.

Royal College of Surgeons of England

TERMS OF REFERENCE FOR CLINICAL RECORDS REVIEW

Review of Urology clinical records at Southern Health and Social Care Trust under the Invited Review Mechanism.

Background

The review team will consider the standard of care provided to patients in a sample of clinical records provided by Southern Health and Social Care Trust for patients that had been under the care of Mr O'Brien, Consultant Urologist.

Review

The review will involve:

- A clinical record review of up to 100 cases from period January 2015 – December 2015 of put forward by the Southern Health and Social Care Trust

Terms of Reference

In conducting the review, the review team will consider the standard of care demonstrated in the clinical records provided by the Southern Health and Social Care Trust including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures;
- Communication with the patient, their family and the GP, and patient consent;
- Team working including communication with other members of the care team, MDT discussions and working with colleagues;
- Follow-up action on the patient care (for example, ordering diagnosis/onward referral to other specialties (oncology etc).
- Actions taken as a result of Multidisciplinary Meeting recommendations
- Administration in connection to the patients episode

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.

- May make recommendations for the consideration to the Medical Director of Southern Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on [date].

Stinson, Emma M

From: Wallace, Stephen
Sent: 15 December 2020 12:55
To: Wallace, Stephen ([redacted])
Subject: MNOTES - 15.12.2020 11:30am UHB Apprisal and Revalidation

Bill Tunnicliffe
Maria O'Kane
Stephen Wallace

BT - AMD for Revalidation, layered structure. RO is separate from the MD – soft intelligence. Takes my information and recommendations, hard intelligence. In house – 8 years ago. Trust went through structural changes. Had to make appraisal processes uniform across four legacy organisations. Issues of self-declaration, requiring the doctor to declare if they have any other licensed activities. It is entirely reliant on the honesty of the doctor. This is set by the GMC requirements. Private providers are now more concerned with practitioners information being included in appraisal and revalidation processes. ISPs are asking for sharing of information, the doctor owns the appraisal not the organisation. BT – the process is for the doctor, GMC state that appraisal is not a performance management tool. Bringing on board an **Annual Professional Review**, job planning, performance, organisational processes around the doctor. This process belongs to the organisation. The doctor will be subject to performance management via this route. MOK – will CSCG be part of professional review, BT – yes this will be included in this. Designated bodies should not burden the A&R with local processes. MOK – private sector providers – take a view that doctor is renting a room rather than responsible for their practice. Letters of good standing require doctor to assure that the outcomes are in line with what their substantive roles are. The exceptions are limited in terms of doctors who's private practice differs from their substantive role. Doctors choose their own appraiser in UHB. Ian Paterson did not declare. The coding system is not reliable to identify deviations in practice. Every appraisal summary is signed off by the AMD A&R for quality purposes. MOK do you audit your appraisals, BT – rather work on a better appraisal than deeper audit of appraisal. BT – I am an appraiser, usually difficult doctors are handled.

Stinson, Emma M

From: OKane, Maria
Sent: 09 December 2020 11:01
To: Wallace, Stephen
Subject: FW: IPR's

Can we discuss???

From: Gibson, Simon
Sent: 09 December 2020 08:44
To: Reid, Trudy; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

See below

Individual Performance Review

Kind regards

Simon

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

From: Reid, Trudy
Sent: 09 December 2020 08:44
To: Gibson, Simon; OKane, Maria; Wallace, Stephen
Subject: RE: IPR's

Simon I have a mental block, what is it?
Trudy

From: Gibson, Simon
Sent: 09 December 2020 08:28
To: OKane, Maria; Wallace, Stephen; Reid, Trudy
Subject: RE: IPR's

P>S – If you don't have one, I'm sure we could all help you put one together as a baseline document

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust

Personal Information redacted by the USI

Personal Information redacted by the USI

[redacted] (DHH)

From: OKane, Maria
Sent: 09 December 2020 08:26
To: Wallace, Stephen; Reid, Trudy; Gibson, Simon
Subject: FW: IPR's

What are iprs?

From: Devlin, Shane
Sent: 08 December 2020 11:07
To: Beattie, Brian; Magwood, Aldrina; McClements, Melanie; McNeany, Barney; OKane, Maria; O'Neill, Helen; Morgan, Paul; Toal, Vivienne; Trouton, Heather
Cc: Alexander, Ruth; Campbell, Emma; Stinson, Emma M; Gilmore, Sandra; Griffin, Tracy; Mallagh-Cassells, Heather; Livingston, Laura; PADirectorofP&RSHSCT; Willis, Lisa
Subject: IPR's

Dear All

At our next 1:1 meetings we will be discussing IPR's for 2019/20 and 2020/21. Can I ask that you do two things in advance of the meeting.

1. Please review your 2019/20 IPR noting achievements (up until 31st March 2020) and forward to me.
2. Based on 2019/20 IPR produce for 2020/21 a roll forward of those items not achieved in 2019/20. I would then suggest a general statement, which I will prepare, to go into all IPR's with regards to managing the organisation through the COVID-19 pandemic

Given the year of COVID we have had, I think this is a fair approach to IPRs for 2020/21.

We will for 2021/22 have a modified approach and I will discuss this further.

Many thanks, Shane

Stinson, Emma M

From:	Wallace, Stephen
Sent:	13 October 2020 10:53
To:	Devlin, Shane
Cc:	OKane, Maria; Trouton, Heather
Subject:	Hyponatraemia Oversight - Updated ToR and Lead Role
Attachments:	Terms of Reference - Hyponataemia Oversight Group Updated 05102020 (3).docx; Hyponatreamia Lead 8B.DOCX

Hi Shane,

As requested and per discussions with Maria and Heather please find attached revised terms of reference for the Hyponatraemia Oversight Group and proposed time limited lead role to coordinate the project. We are in agreement that the role as specified will serve to pull together all elements of the project and provide the oversight and assurances sought by both SMT and Trust Board.

We would be grateful if you can confirm this is something that you are willing to support for 9 months and within which service area you / SMT feel the lead role should rest.

Thanks
Stephen

Terms of Reference

Trust Oversight Group into the Inquiry into Hyponatraemia Related Deaths – October 2020

Terms of Reference of Oversight Group

The Trust Oversight Group into the Inquiry into Hyponatraemia Related Deaths is responsible for providing direction, support and oversight of improvement and systems strengthening work to implement the 96 recommendations contained in the Inquiry into Hyponatraemia Related Deaths (2018).

The oversight group will provide clarity and transparency of function; drive quality and safety and provide assurance to Trust Senior Management Team and Trust Board, as well as the public, pertaining to the recommendations made from the Inquiry into Hyponatraemia Related Deaths.

The function of the oversight group is to:

- Perform a baseline gap analysis with regard to all 96 Report recommendations of report
- Create an action plan complete with named action leads and time scales for targeted improvements to address recommendations
- Establish sub-groups as required to progress specific elements of work relating to implementation of recommendations
- To provide monitoring and oversight of progress towards implementation actions relating to recommendations
- Ensure that there is an improved overall compliance to the recommendations through the including the review and monitoring of the Public Health Agency Staff Training Competency Framework
- Provide oversight of audits relating to recommendations and their findings to provide assurance
- Support and encourage incident reporting processes among all staff of all directorates
- Escalate and identify any barriers, concerns or risks to improvement identified to Trust Senior Management Team

- Work collaboratively across multidisciplinary stakeholders to ensure the best and safest outcomes for service users

Membership of Oversight Group

Membership of the Oversight Group is as follows:

- Dr Maria O'Kane, Acting Medical Director – Joint Chair
- Heather Trouton, Executive Director or Nursing – Joint Chair
- Melanie McClements, Director of Acute Services
- Vivienne Toal, Director Human Resources and Organisational Development
- Dr Tracey Boyce, Director of Pharmacy
- Dr Bassam Aljarad, Consultant Paediatrician
- Ronan Carroll, Assistant Director, Acute Services Surgery
- Grace Hamilton, Assistant Director Nursing Governance
- Dawn Ferguson, Assistant Director Nursing and AHP Workforce
- Anne McVey, Assistant Director Acute Services MUSC
- Bernie McGibbon, Head of Service CYPS
- Dr Phillip Murphy, Associate Medical Director, MUSC
- Dr Mark Haynes, Associate Medical Director, Surgery
- Lynn Woolsey, Assistant Director, Nursing Workforce Development
- Stephen Wallace, Assistant Director Clinical Social Care Governance
- Marita Magennis, CYPS Governance Coordinator
- Paul Morgan, Director, Children and Young People Services
- Eileen Mullan, Non-Executive Director
- Dr Damian Scullion, Associate Medical Director, ATICS
- Tony Black, Governance Coordinator, MHLD
- Claire McNally, Governance Coordinator, OPPC

Other staff may be co-opted in depending on information required. Members should aim to attend all meetings. Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair.

Frequency of Meetings:

- The group is a task and finish group and the anticipated timescale for completion of this work is 12-18 months.
- Meetings will be held monthly, this will be reviewed as required
- It is proposed that each meeting should not last more than 2 hours

Risk Assessment

The Oversight Group will create a Risk Register when considering the Inquiry recommendations. Areas of risk will be communicated to SMT by the Oversight Group Chair. These, where appropriate, will be cross referenced with any findings made by Internal Audit to ensure that all risk is addressed and minimised.

The Oversight Group have identified a key risk for the Trust "as failure of the Trust to implement actions in response to the recommendations into the Inquiry into Hyponatraemia".

Authority/ Delegated Powers

- The Oversight group is authorised by Governance Committee

- To progress or investigate any activity within its terms of reference to satisfy SMT that effective assurances have been made to implement the 96 recommendations and that patient safety is upheld

Reporting and Communication

The Oversight Group will report to Trust SMT monthly and produce Progress Reports for Trust Board as requested.

The quorum for the meeting will be no less than 50% of the membership and must include as a minimum the Chair or a nominated deputy; at least 2 Nurses and two Doctors; and clinical representation appropriate to the agenda items.

Reporting Structure

The minutes of the group shall be formally recorded and distributed to the members of the group and circulated to the Senior Management Team for information and action where appropriate.

The oversight group will provide a report to Governance committee 6monthly.
A report will be provided to Trust Board as part of the Medical Director's report.

Revision Dates

The group Terms of Reference will be reviewed at least annually

Agenda items and Papers for Meetings

Agenda items should be submitted to the corporate clinical and social care governance team [redacted] 10 days in advance of the meeting.

Irrelevant information redacted by the USI

The content of the agenda will be approved by the chair. Agenda and papers for the meeting approximately 5 days in advance of the meeting, to enable the members to have the opportunity to read information in advance.

Southern Health and Social Care Trust

Quality Care - for you, with you

Job Description

Post **Hyponatraemia Lead for 9 months**

Grade **8B**

Department

Base

Reports to

Responsible to

Job Summary

Risks associated with suboptimal fluid management in children are well documented. As a result, reducing the risk of hospital acquired hyponatraemia has been the focus of significant efforts across the health service for some years. Following inspections RQIA made recommendations in 2008 and again in 2010 to improve HSC Trust arrangements to reduce risk in this area.

The O'Hara Inquiry into Hyponatraemia-related deaths (2018) raised serious concerns about the standard of healthcare delivered to five children who tragically died in Northern Ireland as a result of hyponatremia related illnesses between 1995-2001. The report also identified system failures in the investigation of the deaths and made 96 recommendations for HSC organisations in order to improve the safety and quality of care delivered.

The purpose of this post is to drive forward the actions required to achieve these recommendations within the SHSCT. Where the implementation of recommendations is the responsibility of operational directors, the post holder will work in collaboration with operational leads to ensure the Trust is fully compliant with these recommendations.

S/he will chair an implementation group comprising of the key stakeholders including operational leads, project manager and CSCG support staff to progress this work.

S/he will report on progress against these recommendations to the Trusts Hyponatraemia Oversight Group.

Key result areas / Main responsibilities

Setting direction

1. Convene, co-ordinate and chair the Hyponatraemia Implementation Group to ensure that the recommendations are actioned and progressed within the Trust.

2. Establish appropriate reporting structures and assist with the development of solutions to progress outcomes ensuring appropriate mechanisms for escalation where barriers to compliance exist

3. To provide support regarding the implementation of clinical recommendations where the responsibility for enactment and assurance is the responsibility of operational directorates

4. Report on progress against each recommendation to the Trust Hyponatraemia Oversight Group and Trust SMT.

5. Provide clear and concise direction to stakeholders in Acute, and Paediatric Clinical services in the Trust, around the expectations within the clinical recommendations 10 -30.

6. Support the strategic review and improvement of services, in particular making use of improvement methodologies. Resultant outcomes to include, improved service user and staff satisfaction, service effectiveness and value for money.

7. Contribute to development of a Trust-wide learning culture that supports the ethos of lessons learnt to facilitate expertise, knowledge and skills sharing to ensure overall improvement in safety and quality and outcomes for patients and services.

Service delivery

8. Co-ordinate the Implementation and Oversight Groups, ensuring there is appropriate reporting mechanisms in place. The post holder will establish and implement a project management structure to these groups, ensuring that progress is made to achieve successful outcomes.

9. Lead the development of programmes of work to ensure the achievement and maintenance of all recommendations regarding the reduction of risk from Hyponatraemia.

10. Support and progress action plans and audits, collaboratively and energetically working through barriers to identify achievable solutions.

11. Work with clinicians, senior managers and frontline staff to understand situations or information within their sphere of work and develop practical solutions to ensure

implementation of the recommendations.

12. Lead the development of monitoring reports and produce a regular suite of information and other management reports on progress on the Hyponatraemia recommendations, for Trust Board, the Executive Quality Improvement Steering Group, Associate Medical Director Forum, and other sub committees.

13. Drive improvement as well as identifying areas of good practice and excellence.

14. Provide specialist advice, enhanced support, performance improvement expertise and guidance to senior managers, clinicians and staff in respect of service/s under their remit to reduce the of risk of Hyponatraemia to CYP in the Southern Trust.

15. Monitor the implementation of the Southern Trust's Nursing and Midwifery competency framework for the prescription, administration, monitoring and review of intravenous fluids for children and young people, ensuring that there is progress in implementation and compliance.

16. Support the relevant Assistant Directors to implement the Internal Audit recommendations regarding the Management of Children in Adult Wards and Management of Intravenous Fluids to reduce the risk of harm.

17. Work closely with all stakeholders to identify and highlight areas of non-compliance/lack of progress, reviewing possible solutions for consistency and escalating as required.

18. Develop strategies, systems, policies and procedures to address the key areas of risk, which support achievement of the recommendations within the Trust.

19. Challenge the service teams, to ensure areas where performance is unsatisfactory and improvement is required are identified, addressed and implemented.

20. Prepare responses to regional and national reports and recommendations from regional statutory and other bodies as required.

21. Translate regional guidance and standards in relation to relevant services into the Trust's context. Identify the implications for processes and systems and ensure that the necessary changes are disseminated and implemented within designated timeframes.

22. Work with operational to develop and provide any general or specialist training and education programmes to ensure as high compliance as possible in this area.

23. Work with directorate leads to develop strategies to improve training deficits, and supporting them to target shortfalls if noted.

Collaborative Working

24. Work collaboratively with operational and corporate Assistant Directors and senior managers and external organisations, and represent the Trust on local and regional groups.
25. Work directly with relevant internal departments to ensure a seamless approach to the implementation of recommendations and agreed work plans, ensuring the provision of accurate and timely information as required..

26. Work collaboratively at a regional level with DOH, HSCB, PHA and other Trusts to identify and implement best practice in pursuit of enhanced performance and assurance.

27. Work with a range of multidisciplinary stakeholders to develop a Policy for Safeguarding children in an Adult care setting in the Southern Trust

Communication and Information Management

28. Implement and maintain systems and procedures to inform and receive feedback on the services from stakeholders. Evaluate that feedback and take appropriate action for continuous improvement and implementation of recommendations made.

29. Review and evaluate audit outcomes and support stakeholders to take forward any improvement strategies to increase compliance improving outcomes and developing a learning culture.

30. Provide and present quantitative and qualitative reports for Trust Board, SMT, and other appropriate groups, on the work ongoing, implementation of recommendations, audit findings and actions to give assurance of safe and effective patient care.

Quality

31. Ensure that the needs of patients, clients and their carers are at the core of the services provided.

32. Benchmark performance against local, regional and national standards.

33. Support senior operational managers and staff to meeting hyponatraemia recommendations relevant to their areas of responsibility

34. Facilitate programmes to improve compliance with fluid management for CYP in order to improve quality and safety performance deploying appropriate improvement methodology, toolkits, training and coaching as required.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

35. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

36. Maintain staff relationships and morale amongst the staff reporting to him/her.

37. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

38. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

39. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

40. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

General Management responsibilities

41. Adhere to the Code of Conduct for HPSS managers which states that managers will be expected to work with integrity, honesty and openness, probity, accountability and respect, available on www.dhsspsni.gov.uk.

42. Ensure the appropriate governance and risk management arrangements are in place for the services you are responsible for and take appropriate action to identify and manage risk and to maintain safety of users, staff and others in accordance with relevant regulations, policies and procedures;

43. It is essential to ensure that the highest standards of infection prevention and control are maintained to ensure patient and client safety and maintain confidence in the Trust. As a Manager, you must ensure that you implement all instructions/ policy in this area and that all staff are made aware of and fully comply with these.

44. Where the post holder has responsibility for managing a budget, ensure that services are managed and developed both in accordance with agreed and funded priorities as set out on a yearly basis and in accordance with Standing Financial Instructions, particularly ensuring your compliance with payroll documentation procedures and timescales;

45. Ensure the necessary arrangements are in place in regard to the 'Knowledge and Skills Framework' outlines, where this applies, for the posts for which you have management responsibility. Ensure that each member of staff has an annual development and performance review, a personal development plan and that arrangements are in place to ensure that staff have maximum opportunity to progress through gateways in their pay bands and to contribute effectively towards our objectives;

46. Promote a culture of continuous service improvement amongst your staff, encouraging their participation and that of service users in reviewing and modernising current services and in service development;

47. Make sure you are trained and competent in the relevant policies and procedures which apply to the management of staff and other resources and abide by these policies; seeking advice as necessary from senior management or specialist staff as necessary;

48. Communicate effectively with staff and maintain productive working relationships amongst your staff and with others;

49. Delegate appropriate responsibility and authority to staff in order to ensure optimum and effective service delivery and decision-making, whilst retaining overall accountability and responsibility for outcomes;

50. Promote a culture of learning and development and facilitate arrangements for and participate in training and development of staff as agreed for the performance of their duties. Where training is in accordance with relevant standards make sure you have the relevant competences in order to carry out this responsibility;

51. Promote equality of opportunity for all by personal action, both in the management of your staff and in the provision of care to service users in accordance with the Trust's Equality of Opportunity Policy and Equality Scheme;

52. Take responsibility for ensuring appropriate standards of environmental cleanliness and for encouraging staff to maintain standards in their work area. Have an awareness of environmental issues and take appropriate action, for example to ensure the efficient use of energy and other resources, recycling etc.;

53. Make sure that staff are aware of trust policies regarding the Data Protection Act 1998, the Freedom of Information Act 2000, the Environmental Information Regulations 2004

and Records Management and that they must not disclose, withhold, retain or dispose of any information unless legally authorised.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

8. Take responsibility for his/her own ongoing learning and development, including full

participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

10. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the band may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

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

PERSONNEL SPECIFICATION

Title of Post: **Hyponatraemia Lead**

Band of Post: 8B

Salary: £46,626 - £57,640

Hours: 37.5 hrs per week

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*
4. *Volunteering experience may be considered appropriate in particular for roles within the context of direct patient/client care.*

ESSENTIAL CRITERIA		
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.		
Factor	**Criteria**	**Method of Assessment**
Qualifications/ Registration/ Experience	1. University Degree or a relevant[1] professional qualification **AND** 4 years' experience as a Band 7 or above OR 2 years' experience as a Band 8A or above	Shortlisting by Application Form

	2. 2 years' experience in demonstrating personal responsibility for achieving measurable improvements in outcomes for services 3. 2 years' experience working with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes, 4. 2 years' experience in demonstrating personal responsibility for achieving measurable improvements in outcomes for services	
Other	5. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities/Knowledge	1. Knowledge of Hyponatraemia Inquiry and associated recommendations 2. Have an ability to provide effective leadership 3. Have high level interpersonal, verbal and written communication skills 4. Demonstrate evidence of improvement in service outcomes 5. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement. 6. Demonstrate evidence of using own initiative in managing priorities to achieve successful outcomes. 7. Ability to extract, analyse, interpret	Interview

	and present complex statistical information from a range of HSC systems/sources.	

[1] Relevant will be defined as a nursing, social work or AHP degree

Essential Leadership Capabilities:

The successful candidate will need to provide evidence and demonstrate their Leadership capabilities against the required dimension on the NHS Leadership framework.

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified. An assessment centre may also be used as part of the short-listing process.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The dimensions concerned are given in the Healthcare Leadership Model (see below link) http://www.leadershipacademy.nhs.uk/discover/leadershipmodel/leadership-dimensions/

Particular attention will be given to the following:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results

Stinson, Emma M

From: Hynds, Siobhan
Sent: 16 December 2020 16:05
To: Wallace, Stephen
Subject: LPP Information redacted by the USI

Attachments:

LPP Information redacted by the USI

LPP Information redacted by the USI

[redacted]

[redacted]

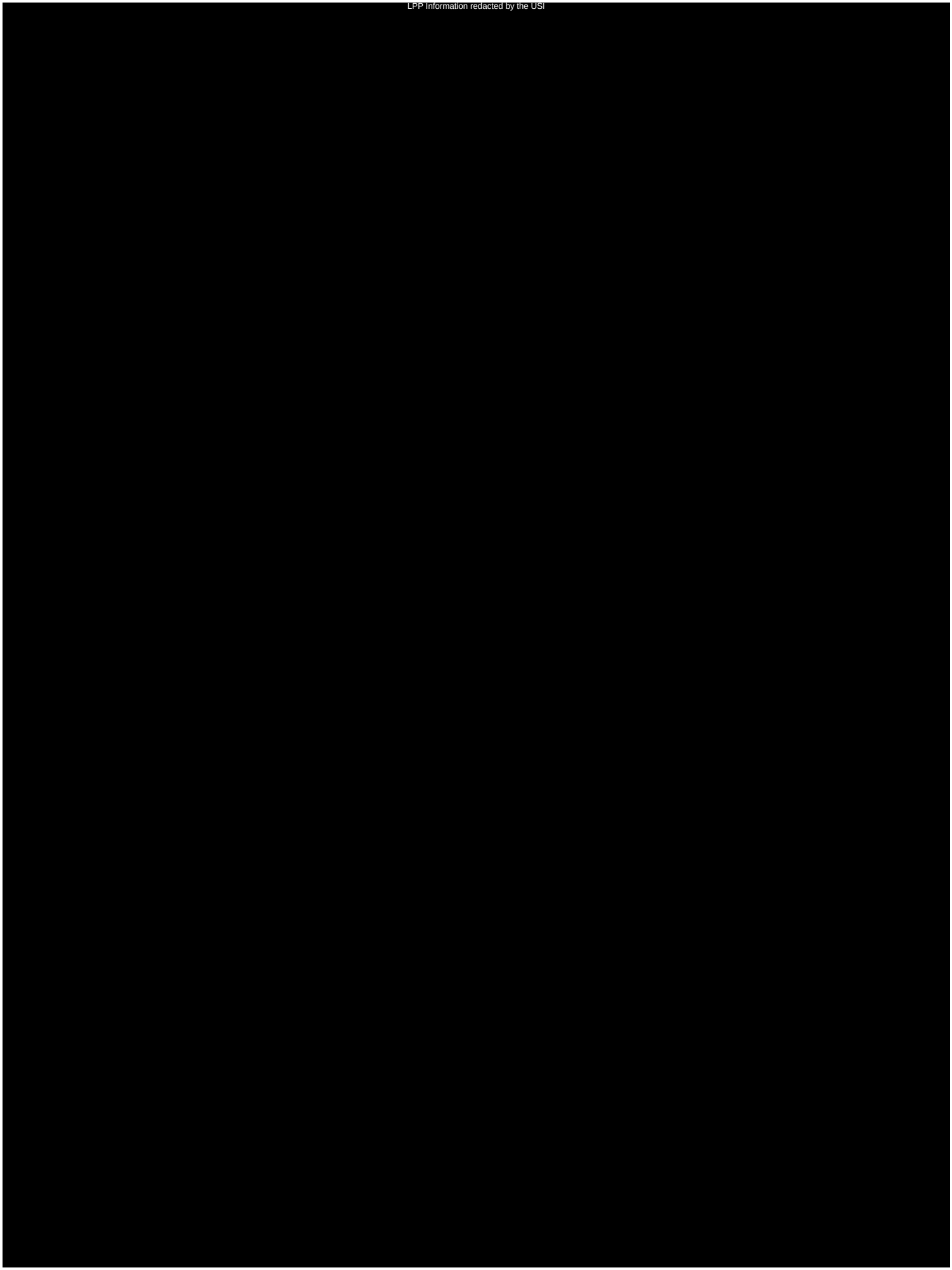
LPP Information redacted by the USI

LPP Information redacted by the USI

[redacted]

LPP Information redacted by the USI

[redacted]



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Corporate Governance and to facilitate FOI requests.

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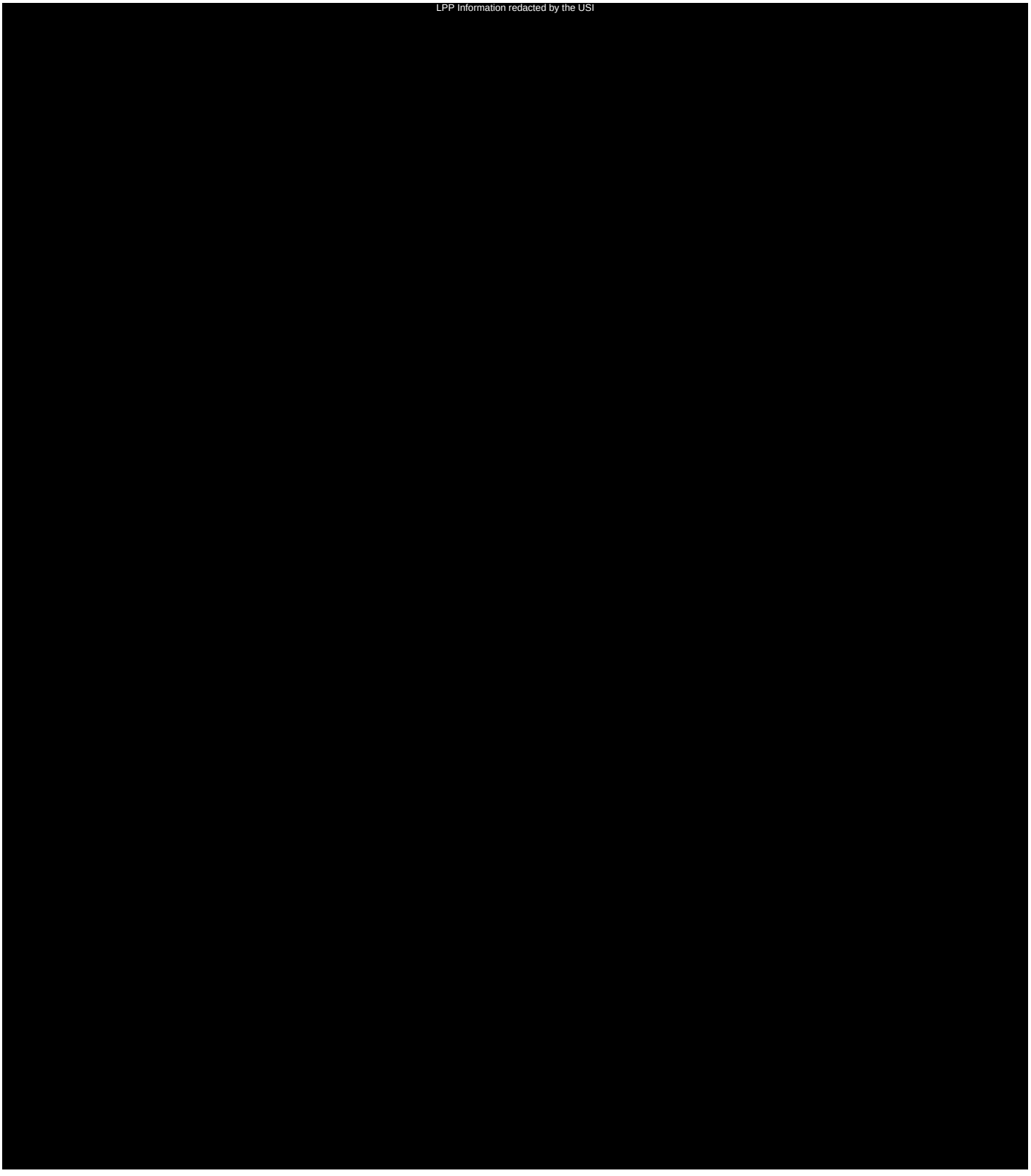
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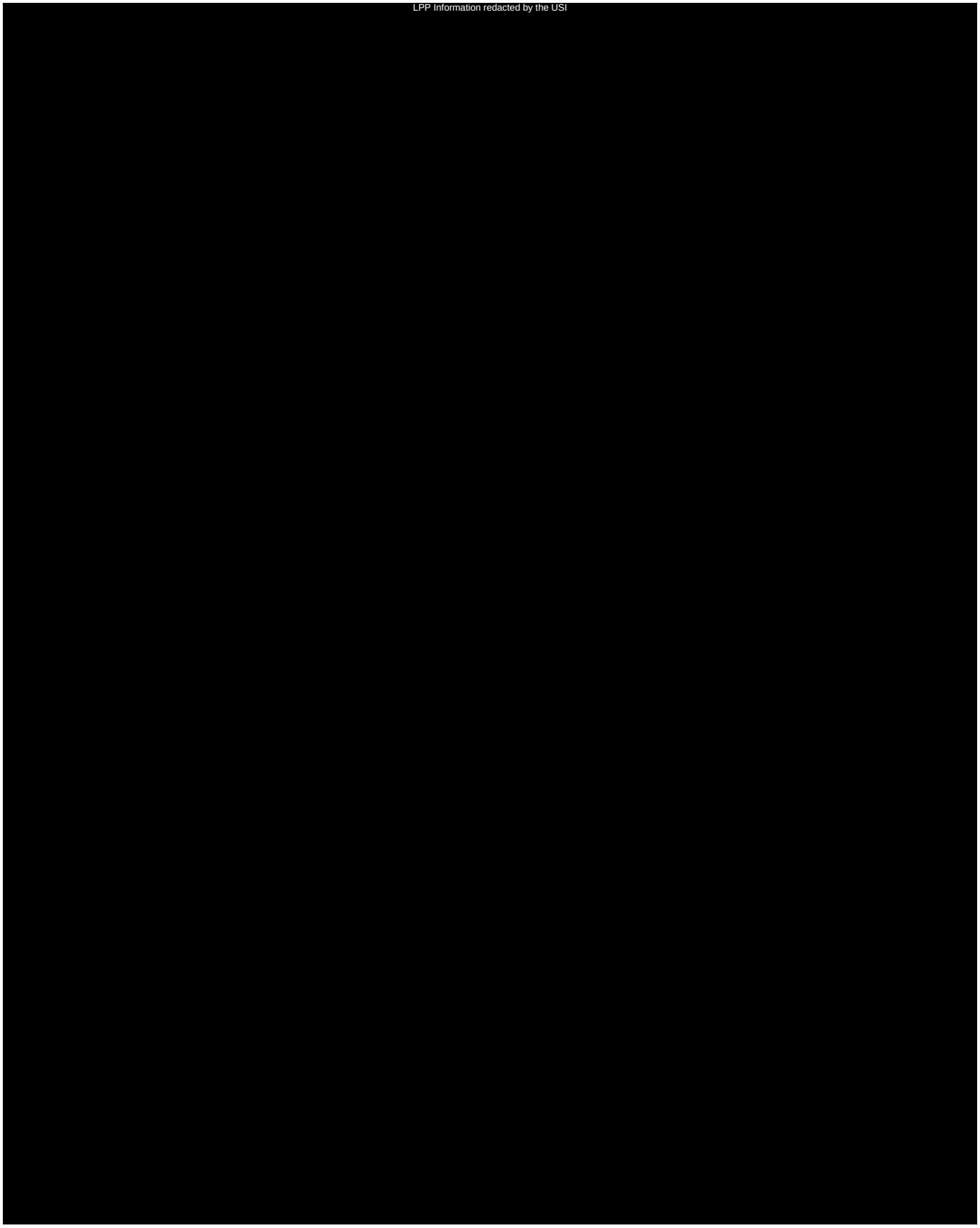
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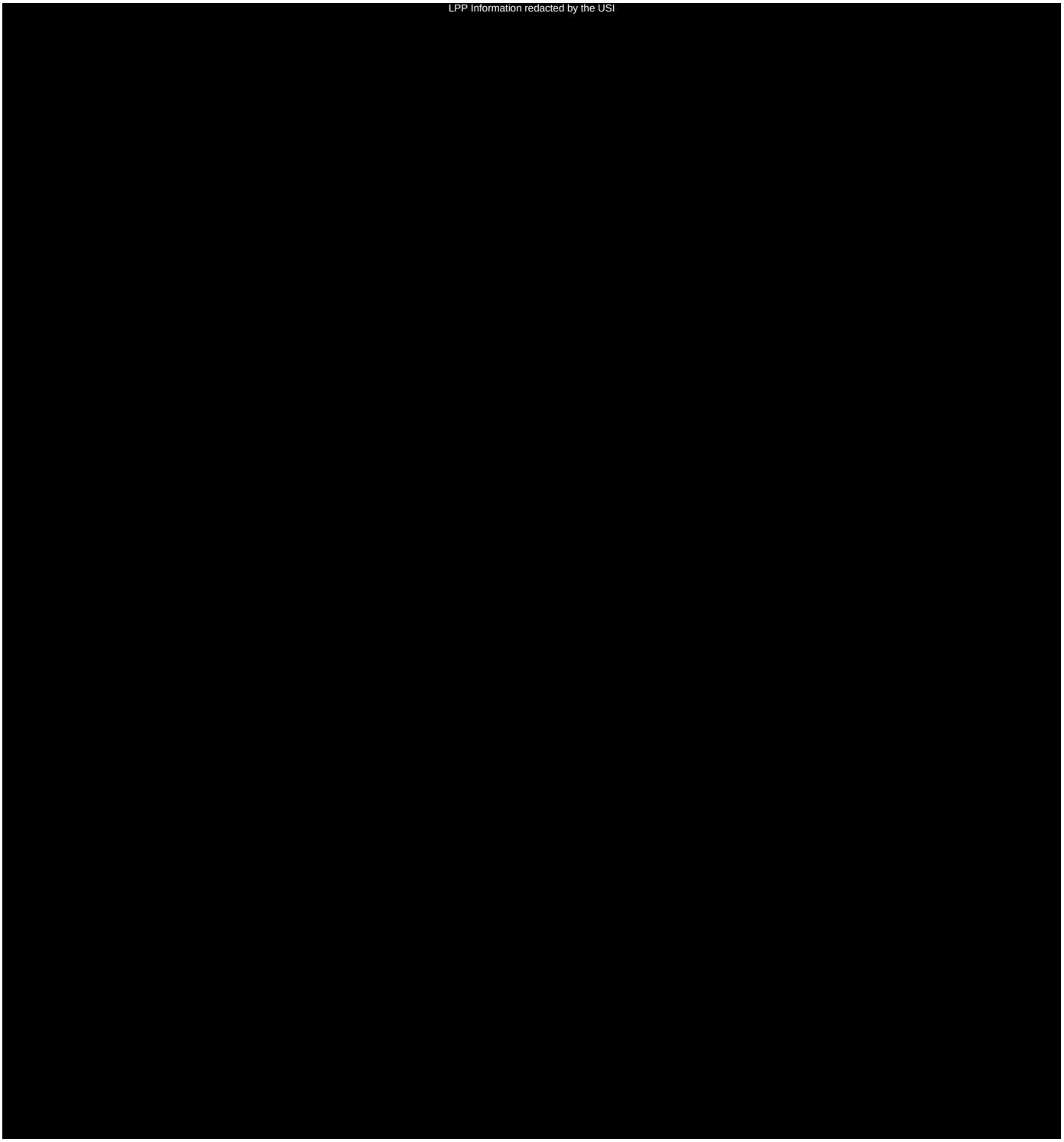
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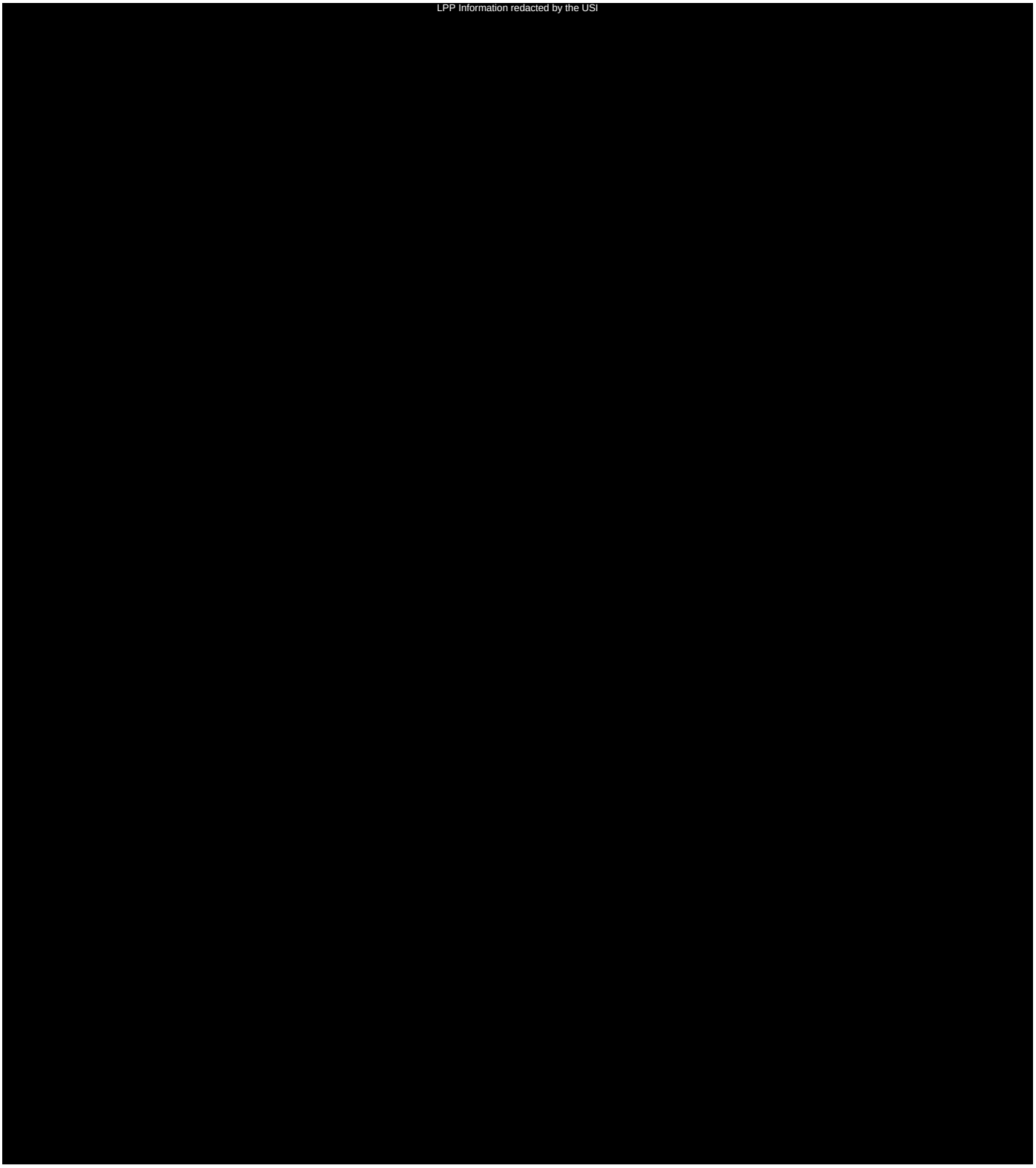
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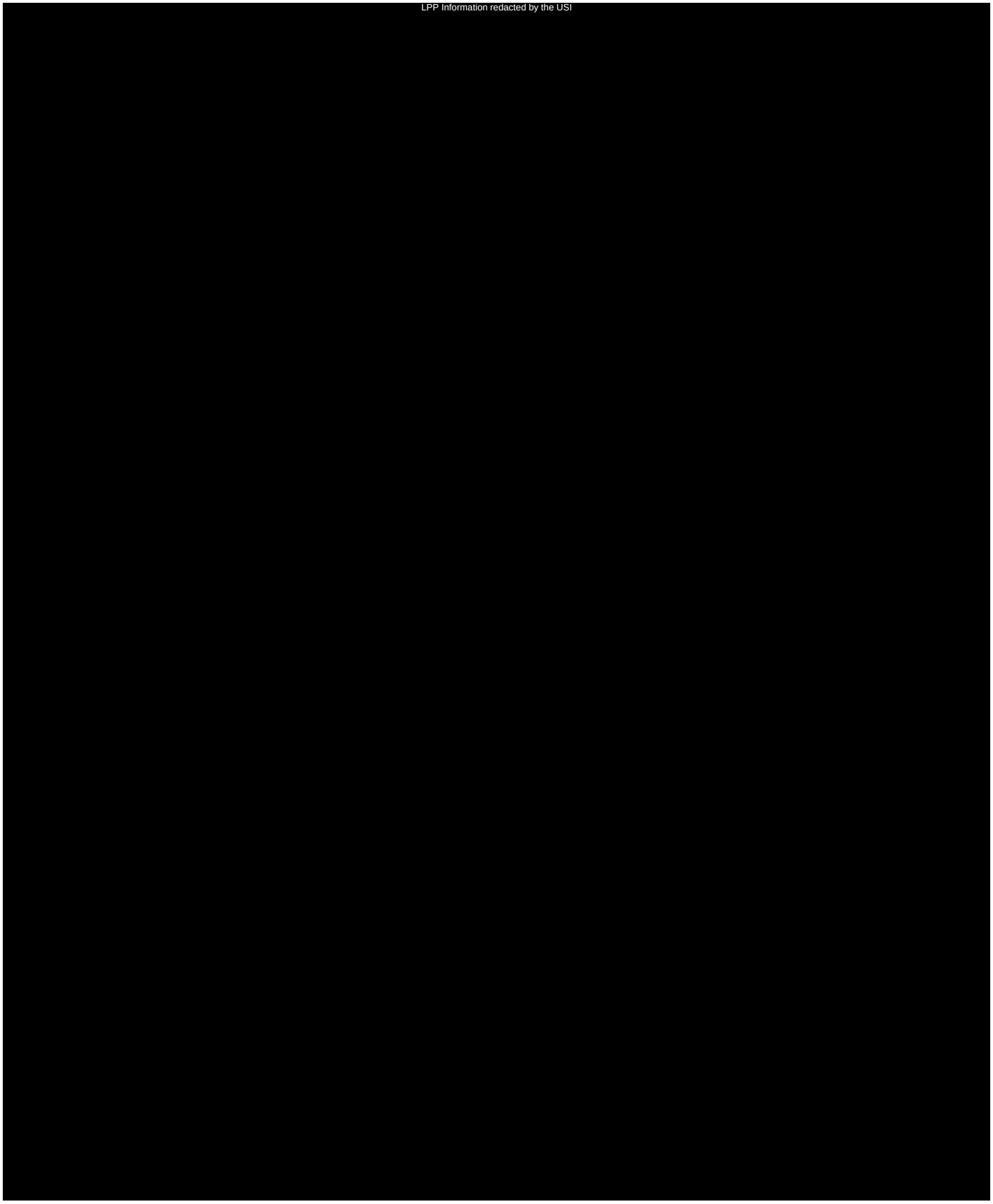
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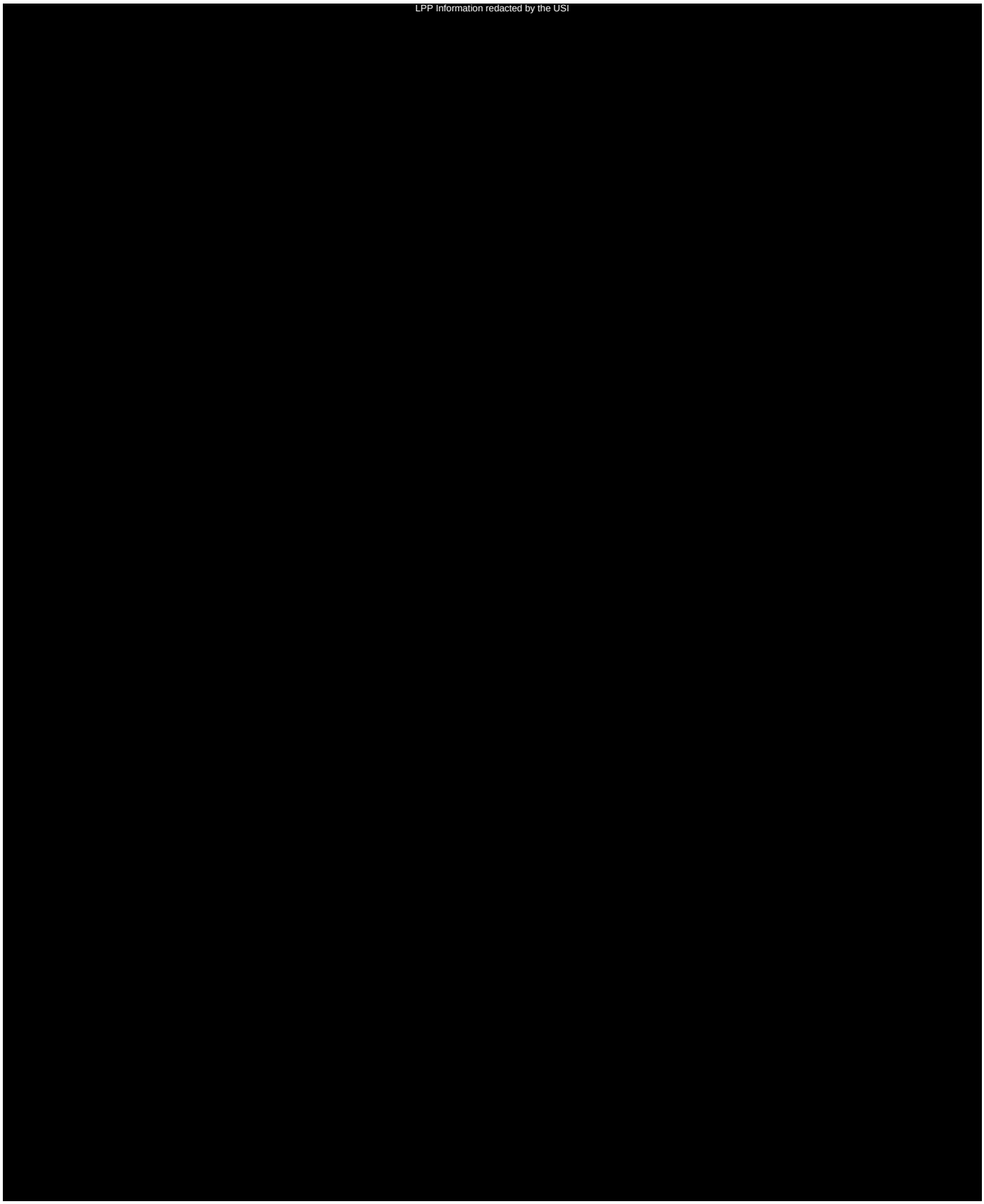
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Stinson, Emma M

From: Best, David <Personal Information redacted by the USI>
Sent: 18 December 2020 09:21
To: OKane, Maria
Cc: Johnston, Julian; Wallace, Stephen
Subject: RE: Indepdendent Medical Examiner

Maria

Excellent news. Over the Christmas period we have decided to pause reviews and we will recommence in the first week of January. The IMEs are meeting on 4 January and we will consider how best to include the Southern Trust and from which date.

As a first step, could you confirm a lead doctor for both Craigavon and Daisy Hill. We will then liaise with them around the practicalities of what is required. We have developed an information sheet for dissemination to medical staff and essentially, we just need that to be distributed and for doctors to be aware that the process is starting. We will confirm a start date, following our meeting with the IMEs on 4 January.

Thanks

Davy

From: OKane, Maria Personal Information redacted by the USI
Sent: 18 December 2020 00:12
To: Best, David <Personal Information redacted by the USI>; Johnston, Julian <Personal Information redacted by the USI>
Cc: Wallace, Stephen <Personal Information redacted by the USI>
Subject: FW: Indepdendent Medical Examiner

Dear Julian / Davy,

Further to the meeting held with the Stephen and Damian last week regarding the newly established regional Independent Medical Examiner role the Southern Trust would be pleased to participate in the next phase of the project.

Can you advise what steps we need to take to commence this?

Regards
Maria

Dr Maria O'Kane
Medical Director

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

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Southern Health and Social Care Trust

Chief Executive – Medical Director
1-1 Meeting
8th March 2021

	Item	Attachment
1	**Urology Update** • SAI Choreography regarding release of reports, CX agreement required • MDM Meetings –Focus on providing assurance around all cancer MDMs priority - Independent Review Process – RCPath contacted, meeting to discuss potential engagement • DLS Funding – need for a dedicated solicitor given inquiry increase , is included in business case	Cancer Quality Surveillance Full polic
2	**Medical Leadership Proposal** • Potential for tabling tomorrow (Tuesday) pending discussions with staff (details from Pat McCaffrey on CD posts and Damian Scullion on patient safety lead posts)	Medical Leadership Implementation Fram DMD JD Template 25.02.2021.docx Job Description - AMD - Primary Care (I Medical Lead for Coroner Services.doc Medical Lead for Litigation Services.do
3	**Appraisal, Revalidation and Annual Management Reviews for Doctors** • Update on the discussion with UHB – potential for Annual Management Reviews to complement A&R processes. Proposal to be develop regarding implementation of the new model.	MNOTES - 15 12 2020 11 30am UHB A
4	**Individual Performance Review** • Shane to discuss what will be required for IPR re Medical Director	FW IPR's.msg
5	**Hyponatraemia** • Hyponatraemia 8B being advertised this week as secondment. • Recommendation stocktake event is scheduled for the first week of April.	
6	**Kings Fund Proposal** • Final spec to be agreed to return to the Kings Fund • Meeting with Nigel Edwards from Nuffield taking place next week • Also have attached Lord Rose report on NHS Leadership	Lord_Rose_NHS_Report_acc.pdf Southern Health and Social Care Trust NI F

7	**MLA Queries Complaints** • Currently the Trust has a 10 day response time set. This is from Mairead McAlindens time to improve MLA relationships. The rest of the regional Trusts have a 20 day response time Volumes now make this challenging (30 received in a single day alone) can this be realigned with the region – comms to be issued regarding this	
8	**Independent Medical Examiner** • Agreement from the DoH that the SHSCT will be next in line to have access to the regional medical examiner pilot. • This was due to go live in mid-January for the SHSCT however was postponed due to Surge 3. Final date for commencement to be confirmed.	 RE Indepdendent Medical Examiner.msg
9	**Colorectal Surgery** • Wasn't sure re this one re GMcA	
10	**Obs and Gynae** • Never Event - Retained Swab • Whistleblowing Update • Development of Dashboard	
11	**Cervical Cytology Service** • Proposal paper • Contact made to PHA re funding	 Cervical Cytology Service Position pape
12	**CSCG Staffing Proposal Update** • Two posts are commencing recruitment this month – 8a Patient Safety and 7 Patient Safety Strategy Lead • Fiona Davidson's career break is due to continue until July. Fiona has indicated she is willing to come back for 2-3 days a week. Can this be funded • Phase 2 of CSCG Proposal to be approved (attached) • 80% of posts in CSCG are acting or temporary, need to steady structure • Proposal for the bringing CSCG under corporate leadership in development	 Phase Plan.docx
13	**Unscheduled Care Centre Governance** • Clinical Governance for the UCC will sit with ED DMD post – proposal to be finalized.	
14	**Morbidity and Mortality (including COVID-19 deaths)** • Proposal to develop a separate mini M&M to support COVID inpatient mortality reviews, both nosicomial and community deaths. Meeting planned to be held weekly to clear backlog. • Part of strategy will serve to potential reform M&M meetings as Patient Safety meetings with learning from mortality an input along with other safety data	

15	**Patient Advice and Liaison Service** Meeting with Heather has been held to potentially redevelop the PaLS service. Meeting next week to decide potential form of service.	Patient Experience Officer- band 4 JD- Ja 2962039_PALSOfficerJD.doc
16	**Structured Judgement Review** • SJR Training is due to take place on the 18th and 25th March. 20 Trust doctors in total will be trained, the training model is designed for cascade training. • Regarding applicability to Urology -the Trust is engaging an additional independent consultant urology expert with experience in SJR methodology to support.	
17	**Weekly Governance Report** • David Gilpin has commenced in 2PA role to support SAIs	Weekly Governance Report 22.02.21 - 28

Cancer Quality Surveillance Policy

Key Document code:	WAHT-KD-023	
Key Documents Owner:	Elaine Stratford	Cancer Quality Assurance Manager
Approved by:	Cancer Board	
Date of Approval:	23rd May 2019	
Date of review:	23rd May 2021	

Key Amendments

Date	Amendment	Approved by
9th March 2017	Revert to Original text in document in relation to referring to 'immediate risks' and 'serious concerns'	Cancer Board
23rd May 2019	Document approved	Cancer Board

Introduction

The National Quality Surveillance team was established in April 2015. It is a specialised commissioning directorate within NHS England and is responsible for all specialised services and all cancer services irrespective of how they are commissioned.

The purpose of the National Quality Surveillance programme is to measure both clinical outcomes and the implementation of the service specification by the clinical service against a number of set indicators. These focus on patient experience, clinical outcomes, structure and process. The programme will support the Quality Surveillance Team (QST) in the alignment of specialist services, building a quality profile for each specialised service and to provide a National and regional reporting function. The QST will also provide a responsive and flexible review visit programme in line with regional and National priorities.

The Quality Surveillance programme introduced a new information portal in July 2016 the Quality Surveillance Information System (QSIS). This portal enables each team to submit self-declarations (SD), against a number of specified indicators. It will act as a tool for commissioners to compare and benchmark across providers. Data will also be extracted from other sources such as National audits and surveys, acute and specialist Trust dashboards, CQC visit reports and local mechanisms of gaining feedback.

Data collection will also include sources such as patient experience feedback from the friends and family test, complaints, serious untoward incidents, service reviews, and previous peer review visits.

Self-declaration for cancer services

The Quality Surveillance programme for cancer services will require each team to submit an annual self-declaration. This will be sent out to the clinical teams for them to populate with the required information against the set quality indicators.

Within cancer services, the majority of teams and services will have an internal validation (IV) by an approved panel within the organisation. Information following the IV panel will be transferred onto the QSIS portal by the Cancer Quality Assurance Manager (who is QSIS lead/administrator for cancer services).

All self-declarations will need to be submitted by the deadline specified by the national team.

The National Quality Surveillance team as part of the NHS business plan will be organising external visits. These are in 3 categories:

1. Comprehensive visit

   These will be based on quality indicators and will be agreed nationally with the Specialised Commissioning Programmes Of Care (POC) boards based on national priorities. This will be for all organisations providing that particular service across the country. The schedule for the first of these comprehensive visits will be given by the end of November 2016 and will continue to be provided on an annual basis.

2. Targeted visit

   The National Quality Surveillance team may also request a targeted visit for a service. This would be a planned review to specific services/team informed by annual assessment and agreed with regional specialised commissioned teams, based on local priorities.

3. Rapid response visit

   At any point a rapid response visit may be requested by the National Quality Surveillance team which will be a short notice visit to a specific service/team in response to concerns raised in relation to patient safety.

The visit cycle will predominantly be from January to July, but may extend throughout the year.

Scope of the Policy

This policy is intended to cover all cancer and palliative care MDT's and services across the Trust for which indicators have been developed by the national quality surveillance team NHS England.

Definitions

- Self-declarations (SD): Every year each team/service will complete the self-declaration demonstrating compliance against the national indicators. In addition, the team/service will be required to provide an annual report, a work programme, an operational policy and appendix containing supporting evidence.

- Internal Validation (IV): a process of internal governance by the Trust. This includes a review of the selected teams/services' self-declaration, annual report, operational policy, work programme, and appendix. This will be by a panel with membership from the Trust, Clinical Commissioning Groups (CCG's) and user representation.

- External Reviews will take the form of comprehensive, targeted or rapid response as outlined above.

- 'Dummy run': prior to an announced comprehensive visit, targeted visit or rapid response visit from the national team, there will be a review of the evidence provided by the team/service. This review will take place at least 6 weeks prior to the planned visit, however the time frame may be less depending on the type of external visit requested. If the national team wish to undertake a rapid response visit when the Trust may have as little as 4 weeks' notice of the visit.

  The dummy run will be undertaken by the cancer team reviewing the available documentation to identify any potential areas of concern. The MDT team, directorate, divisional and executive teams will be informed immediately of any potential immediate risks or serious concerns identified at the 'dummy run'.

Responsibility and Duties

Cancer Management Team:

The cancer management team will lead on the IV process and will facilitate external reviews.

The team consists of:

- Associate Medical Director for Cancer Services
- Cancer Manager
- Macmillan Lead Cancer Nurse
- Cancer Quality Assurance Manager
- Cancer Data Information Manager
- Assistant Cancer Data Information Manager
- Macmillan Cancer Information and Support Service Lead
- Cancer services team secretary (for IV)

Associate Medical Director for Cancer Services:

- The Associate Medical Director for Cancer Services is Chair of the Trust Cancer Board, where any outcomes or actions from the Cancer Quality Surveillance process will be noted, discussed and monitored. Minutes from the Cancer Board will be forwarded to the executive team.

- To be responsible for reviewing the teams/services self-declarations and ensuring that any necessary changes are made. Any immediate risks and serious concerns at any stage will be reviewed and escalated to the Chief Executive Officer (CEO) or nominated deputy.

- To chair all IV panels where able (however if the Associate Medical Director for Cancer Services' own team is under review an alternative chair will be identified) and will agree and submit the subsequent report to the CEO or nominated deputy.

- To take part in the 'dummy run' of the team or service to be externally reviewed within a specified timeframe, (normally 6 weeks prior to the review but dependent of the type of review requested by the national team).

- To deliver a brief presentation introducing the selected team or service at any external review.

Cancer Services Manager and Macmillan Lead Cancer Nurse:

- To have overall responsibility for leading the Quality Surveillance programme.

- To be part of the IV panel and will Chair when required.

- To take part in the 'dummy run' of the team or service to be externally reviewed approximately six weeks prior to a visit requested by the National Quality Surveillance team, but this will be dependent of the type of review that has been requested.

Cancer Quality Assurance Manager:

- In discussion with the Associate Medical Director for Cancer Services and the Macmillan Lead Cancer Nurse and Cancer Services Manager develop the programme of internal validations and co-ordinate the external reviews ensuring all the relevant stakeholders have been informed. This will include the assembly of the internal panel, making room bookings and ensuring that the relevant documents have been circulated to panel members. Relevant IT equipment and facilities for use should also be made available.

- To support the teams in completion of the self-declaration documents, annual report, operational policy, work programme and supplementary evidence in the form of appendices, providing guidance regarding format and content.

- To maintain close communication with the national team.

- To be responsible for co-ordinating the internal programme of reviews and also any external reviews.

- Once the teams/services self-declarations have been completed, they will form part of the evidence for both IV and external review (taking the place of what was formerly the self-assessment document).

- To be a member of the IV panel.

- To fulfil the role of QSIS lead/administrator for cancer services, assisting MDT members to register on the portal with appropriate permissions.

- To disseminate all IV and external reports to executive members of the Trust board and the clinical governance department.

- To present the IV and external report findings at the Trust Cancer Board.

- At the national team's request for an external review, to organise and participate in a 'dummy run' and review the evidence provided by the MDT/service approximately 6 weeks before the external visit (or sooner if a rapid response visit is requested).

- To inform the Divisional Director of Operations, Clinical Director, Directorate Manager and MDT Lead immediately of any risks identified at the 'dummy run' and these will be noted, discussed and monitored by the Trust Cancer Board.

- To inform the following members of Trust staff immediately of any immediate risks or serious concerns identified at the IV or external review:

    - The Chief Executive Officer
    - Chief Medical Officer
    - Chief Nursing Officer
    - Chief Operating Officer
    - Deputy Chief Operating Officer
    - Relevant Divisional Medical Director,
    - Relevant Divisional Directors of Nursing,

- Relevant Divisional Director of Operations
- MDT Lead
- Directorate Manager
- Matron

To send the IV panel report to:

- The IV panel for factual accuracy for return of comments/clarification within 14 working days then
- The clinical team for factual accuracy for return of comments/clarification within 14 working days
- To oversee and facilitate the process identified in appendix one.
- To facilitate the Trust CEO response to any risks identified at any external visits.
- To ensure divisional teams are aware of any risks identified in either internal or external reviews and appropriate action plans are in place.
- To enter any immediate risk or serious concern onto the risk register (DATIX) system with the ownership of the risk being with the clinical and operational team. Cancer Board will monitor and review progression of the action plan in relation to the risk register on a regular basis.
- To liaise with divisional clinical governance teams in relation to the risk register.

The Cancer Data Information Manager and Assistant Cancer Data Information Manager:

- To be a member of the IV panel.
- To provide the specific cancer data information as required by Quality Surveillance indicators and to participate in the 'dummy run' of the team or service to be externally reviewed when available.

The MDT Coordinators:

- To use the Somerset Cancer Register live in the MDT meeting to assist in the collection of the specific cancer data information as required.
- To provide any specific information as requested by the cancer quality assurance manager.

Cancer Services Quality Improvement Nurse

- To be part of the "dummy run" of the team or service to be externally reviewed when available.
- To assist in the identification of patient representatives to form the IV panel when required.

Cancer Services Team Secretary:

- To provide administrative support to the cancer services team throughout the Quality Surveillance programme.

MDT Clinical leads:

- To ensure that the team/service has completed the self-declaration, annual report, operational policy, and work programme and that supporting evidence is available in the form of an appendix. These must be completed in the time frames that are specified either by the Trust or the national team.

- To facilitate the engagement of the clinical team in the Quality Surveillance programme.

- To be available for all internal and external validations of their team/service.

- To receive feedback from the IV panel or the national team and to inform the MDT team/service of the outcomes and take appropriate action as required.

- Following notification of any immediate risks or serious concerns the MDT lead working within the operational team is required to respond to cancer services within timeframes specified by the national team. (Responses are required within 10 working days for an immediate risk and 20 working days for serious concerns.)

- To attend the Trust Cancer Board at the request of the Chair.

- To take part in the 'dummy run' prior to any visits from the national team.

- To ensure an operational meeting is held yearly to discuss the Cancer Quality Surveillance programme and relevant evidence documents.

Chief Executive Officer:

- The CEO (or deputy) is responsible for the final approval of the self-declaration produced by the clinical team and ratified by the IV Panel to confirm that it is an accurate assessment of the selected team/services.

- The CEO (or deputy) will approve the self-declarations (following process as outlines in appendix one).

- Following an external visit from the national team, the CEO (or deputy) will be required to attend the High Level Feedback session.

- Following any external visits from the national team, it is the responsibility of the Trust's CEO (or deputy) to formally respond to the Quality Surveillance Team Director, within ten working days of notification of an immediate risk being identified and 20 working days after a serious concern being identified.

- Final approval of reports following internal validations.

Trust senior executives (Chief Medical Officer, Chief Nursing Officer and Chief and Deputy Operating Officer):

- To attend the high level feedback on the day following internal and external reviews.

- The Chief and deputy-chief operating officer will act as the QST leads for the organisation providing final sign off of self-declarations on the QSIS portal and acting as a point of contact for the organisation for communication with the Quality Surveillance team.

The Divisional Medical Directors, the Divisional Directors of Nursing, the Divisional Directors of Operations and Clinical Directors:

- To attend the high level feedback on the day of internal and external reviews when available.

Matrons:

- To participate in the 'dummy run' prior to any external reviews from the National Quality Surveillance Team.

- To attend the high level feedback session following internal or external reviews.

- To assist the MDT Lead and Directorate Manager to produce an action plan following notification of any risks and identified.

Directorate Managers:

- To take part in the 'dummy run' prior to any reviews from the national team

- To attend high level feedback sessions following IV and external reviews by the national team.

- To work with the MDT Clinical Lead to respond with an action plan following notification of any risks identified within timeframes specified by the national team. These are: within 10 working days for any immediate risks and 20 working days for any serious concerns.

- Any action plans developed will be monitored within the Division, and by Cancer Board and will be submitted to the national team as part of their annual assessment process.

- To attend the Cancer Board at the request of the Chair to update on the progress of actions in response to immediate risks or serious concerns.

Representative from Clinical Commissioning Groups:

- A representative from the Clinical Commissioning Groups and will be invited to take part in the Trust's IV as a member of the IV panel.

Table 1: Evidence for Quality Surveillance Review (annual)

Operational Policy	Annual Report	Work Programme
Describing how the team functions and how care is delivered across the patient pathway Outlining policies/processes that govern safe/high quality care Agreement to and demonstration of the clinical guidelines and treatment protocols for the team.	Summary assessment of achievements and challenges Demonstration that the team is using available information (including data) to assess its own service MDT Workload & Activity Data (activity by modality, surgical workload by surgeon, numbers discussed at MDT, MDT attendance) -National Audits -Local Audits -Patient Feedback -Trial Recruitment -Work Programme Update -Information relating to Clinical Lines of Enquiry	How the team is planning to address weaknesses and further develop its service. Outline of the team's plans for service improvement and development over the coming year -Audit Programme -Patient feedback -Trial Recruitment -Actions from previous reviews

Demonstration of agreement

Where agreement of strategic clinical network guidelines, policies, etc. is required, this should be stated clearly on the cover sheet of the relevant evidence documents, including agreement dates and versions. Similarly evidence of Trust guidelines, policies and all three core evidence documents require agreement of the MDT/service lead and the Associate Medical Director for Cancer Services dated and signed on the cover sheet. The agreement by a person representing the group or MDT (chair or lead ,etc.) implies that their agreement is not personal; they are representing the consensus opinion of the MDT.

Time scales for Self –Declaration

The Cancer quality assurance manager will produce an annual Trust Quality Surveillance programme timetable, once they have received notice from the national team of any planned external visits.

It is expected that the national team will inform the Trust by the end of November their timetable of comprehensive external visits for the forthcoming year ahead. In relation to other external visits from the national team, depending on the nature of the visit, the timeframe will be indicated by the national team on request of the visit.

All internal validations must be completed in time for the QSIS portal to be populated with self-declarations based on national indicators as specified by the national team.

Policy Detail

Self- Declaration process

Each team/service MDT Lead clinician will be expected to complete an annual self-declaration. The self-declaration from the QSIS portal will be downloaded and sent to the MDT Lead clinician to complete. Team members are also encouraged to register onto the QSIS portal on a 'read only' basis in order to familiarise themselves with the indicators set by the National Quality Surveillance Team.

Table 2: Key dates for Self -Declaration

Key Dates for teams/services to complete their self-declaration and supporting evidence for internal validation	
Self-declaration and supporting evidence documents from teams/services to be commenced by:	**1st December in the year**
Self-declaration and supporting evidence documents from teams/services to be completed by:	**By date specified by cancer services team**
Internal Validation to be completed by:	**End of 2nd week in June in the year**

Internal Validation

The Purpose of Internal Validation

NHS England stipulates that for all specialised commissioned services and all cancer services, however commissioned, an annual self-declaration is required. It is then for individual organisations to decide their governance processes to provide assurance of compliance to the national quality indicators. These are available on the QSIS portal.

WAHNHST have agreed that each team/service will have an internal validation on an annual basis unless there is a plan for an external visit from the National Quality Surveillance Team. This is to provide a robust clinical governance framework.

The only exception to this is if there are no national indicators for the team or service. This will then be discussed with the operational and clinical team.

By following this process, both clarity and assurances will be provided to the organisation in relation to the information provided from MDT/services against the nationally set indicators.

Process for IV

An IV panel will be selected from the following staff members:

- Trust Cancer Management team
- Patient/Carer Representative
- Nurse Representative
- Clinical Commissioning Groups Representative
- An expert colleague if required

The Internal Validation will be undertaken in one of two ways

- The IV panel will review all the submitted required documents with any points of clarification discussed with the MDT lead via telephone.

OR

- The IV panel will convene; review the submitted documents prior to meeting with representatives of the MDT and operational team to discuss any points of clarification. The representatives will be informed of the date of the IV by the Cancer Quality Assurance Manager a minimum of 6 weeks in advance to facilitate attendance

The IV Process will ensure

- The on-going quality assurance of cancer teams and services across the Trust
- Accountability for the Self-declaration is confirmed by agreement of CEO of the organisation.
- There is Commissioner and Patient/Carer involvement within the process
- The information from the self-declaration and the outcome of the internal validation is transferred onto the National Quality Surveillance (QSIS) web based portal within the timeframes specified by the national quality surveillance team.

The IV Self-declaration

The IV Self-declaration will be completed in real time by the panel and agreed by the panel members prior to the conclusion of the session.

Any risks identified

The MDT clinical team/service may identify following the IV process, three categories of concern relating to their team/service which are

- Immediate Risk
- Serious Concern
- Concern

Immediate Risk

An "Immediate Risk" is an issue that is likely to result in harm to the patient or staff, or have a direct impact on patient outcome and requires immediate action. Any immediate risk will be identified to the MDT/service lead and the CEO or deputy on the same day. A written response from the team/Trust identifying actions to resolve the issue(s) is required within 10 working days. Following IV the response will form part of the Internal Validation SD and will be agreed by the CEO or deputy.

Serious Concern

A "Serious Concern" is an issue, which although not an immediate risk to patients or staff could seriously compromise the quality or outcome of patient care and requires urgent action to resolve. Any serious concern will be identified to the MDT/service lead and CEO or deputy on the same day. A written response from the team/Trust identifying actions to resolve the issue(s) is expected within 20 working days. Following Internal Validation the response will form part of the national teams annual review process and will be agreed by the CEO or deputy.

Concern

A "concern" is an issue that is affecting the quality of the service. It does not require immediate action but can be addressed through the work programme of the MDT/service.

Following Internal Validation or external review, the CEO and senior members of the executive team will be notified of any immediate risk, serious concerns and concerns by the Cancer Quality Assurance Manager. The outcomes will be noted, discussed and monitored by the Trust Cancer Board.

External Visits
The Process

See Appendix 1 -Quick reference guide for External Peer Review visit.

Notification of Visits
It is anticipated that the National Quality Surveillance Team will provide the Organisation with sufficient notification of dates for planned comprehensive visits. The Cancer quality assurance manager will then notify individual teams/services of those dates if they have been selected for review.

Prior to External visits
For any external reviews the Cancer Quality Assurance Manager will organise a 'dummy run'. This is a review of the evidence provided by the MDT clinical team /service approximately 6 weeks before a planned comprehensive visit by the national team, but this could be a much shorter timeframe as dictated by the nature of the visit ie.targeted or rapid response.

This 'dummy run' will involve the cancer team, the relevant MDT lead and Clinical Nurse Specialist, Directorate Manager and Matron. The Divisional Director of Operations, and Clinical Director, will be informed immediately of any areas of concern identified at the 'dummy run' and these will be noted, discussed and monitored by the Trust Cancer Board.

Appendix One – Quality Surveillance – The process

Individual teams/services are made aware of the yearly timetable for their internal/external visit as soon as the cancer management team are aware

Team/service are sent PDF copy of self-declarations from QSIS portal. This must be returned to Cancer Quality Assurance Manager within 2 weeks of the date that the internal review is set for with a copy of annual report, operational policy and work programme.
For external visits, national timeframes will need to be strictly adhered to (this will depend on the type of visit requested)

Cancer Quality Assurance Manager and Macmillan Chemotherapy and Radiotherapy Project Nurse (as QSIS lead/administrators) enter information provided onto the QSIS portal. This information will form part of the review process.

Following the review the outcome of the review including any immediate risks and serious concerns identified are fed back to the MDT lead, executive team and senior members of the operational team.

Following IV the updated SD is generated including comments from the IV team. This is sent to the IV panel for factual accuracy check for response within 7 working days. This is then sent to the MDT/Service lead to disseminate to the team for factual accuracy. For return to the cancer management team within 7 working days.

Once any changes or amendments have been agreed the QSIS portal will be updated by the QSIS lead/administrators.

If any immediate risk and serious concerns are identified a response with an action plan is required within the nationally agreed timeframes i.e. immediate risk within 10 working days and serious concern within 20 working days. These action plans will be agreed at cancer board and monitored by both cancer board and the operational executive group

The agreed action plans will be added to the QSIS portal by the QSIS lead/administrators. The self-declarations will then be reviewed by the Associate Medical Director for Cancer Services. Any changes will be made on the portal by the QSIS lead/administrators

Once all the self-declarations have been approved by the Associate Medical Director for Cancer Services, the QSIS lead/administrators will send the self-declarations for approval.

The QST lead (or nominated deputy) will be notified that the self-declarations have been sent for approval and will review all the self-declarations and approve them. If any amendments are required at this stage they will be sent back to the QSIS lead/administrator to make the required changes.

Appendix Two- Quick Reference Guide: The External Quality Surveillance Team Visit

The Quality Surveillance Team Visit

Documentation
Two weeks before the visit from the Quality Surveillance Team, the visiting reviewers will be able to access, via the QSIS web based portal, the Trust teams/services self-declaration which will have been added, the operational policy, annual report, work programme and appendices which will be uploaded.

They will look for

- Compliance against the indicators
- Supporting evidence

One hard copy of the self-declaration and other submitted documents must be made available by the team/service under review

Timing
The visit will be designed around a sessional structure, as shown in the example below:

Activity	Approximate Time
Review team to review evidence in preparation for meeting	1.5 hours
Meeting with service	2 hours
Review team to write report	1 hour
Review team to give high level feedback to team/service lead	0.5 hour

Logistics

- A minimum of two rooms should be booked in the Trust for the visit, ensuring the room sizes are appropriate for the size of the MDT/Service being reviewed.
- Security passes, car parking and catering arrangements should be arranged ahead of the visit, and the Reviewers advised of the details
- Associate Medical Director for Cancer Services, Cancer Services Manager, Macmillan Lead Cancer Nurse, Cancer Quality Assurance Manager, and members of the Cancer management team to be available to meet the Quality Surveillance team at the start of the visit (if required).
- The Clinical Lead and all core members of the teams/services being reviewed should be available during the Quality Surveillance Team visit

- Members of Cancer Commissioning Services based in the Clinical Commissioning Groups will be made aware of the date of External Peer Review Visit and invited to attend if required.

The Cancer Quality Assurance Manager will assist and facilitate with this process.

Visit Reports

The Associate Medical Director for Cancer Services, Cancer Services Manager, Macmillan Lead Cancer Nurse, Cancer Quality Assurance Manager, MDT lead, senior members of the operational team and an executive of the organisation will receive high level feedback at the end of the day of any immediate risk and serious concerns identified.

The Cancer Quality Assurance Manager will inform via email the executive team, divisional and directorate teams and MDT lead of high level feedback of any immediate risks and serious concerns identified.

Draft reports will be written by the reviewers. The Trust will be given the opportunity to comment on the factual accuracy of the report before it is published.

Any comments relating to the draft report should be submitted in writing to the regional team within 10 working days of receipt of the draft. Any queries will be resolved locally with the regional team in the first instance. Any unresolved queries will be referred by the regional team to the national co-ordinating team.

The report will be received by the Cancer management team and notification sent to the operational team and senior members of the executive team for action within the Trust. Outcomes will be noted, discussed and monitored by the Trust Cancer Board.

Domain	Role		PA Required	PA Currently Funded	Investment Required	Comment
Operational Divisional Medical Director Posts	DMD Surgery and Elective Care		3	2.091	0.909	Previously Funded 3 PA's
	DMD ATICS		3	3	0	Current Incumbent DMD IMWH
	DMD Medicine and Unscheduled Care		4	4	0	
	DMD Integrated Maternity and Women's Health		3	3	0	Current Incumbent DMD ATICS
	DMD Cancer and Clinical Services		3	3	0	
	DMD Emergency Medicine & Unscheduled Care		3	3	0	Previously Funded Position
	DMD Children's and Young Peoples Services		3	3	0	
	DMD Mental Health and Learning Disability		3	2	1	Previously Funded 3-5 PA's
	DMD Older People		3	3	0	Being met with OPPC funds
Corporate Services	AMD Primary Care		4	4	0	
	AMD Infection Prevention and Control		3	3	0	Previously Funded Position
	AMD Research and Development		2	2	0	
	Medical Lead for Coroner Services		0.5	0	0.5	New Post currently unfunded
	Medical Lead for Standards and Guidelines		1	1	0	Previously Funded Position
	Medical Lead for Litigation		0.5	0	0.5	New Post currently unfunded
Clinical Director Structure	Surgery and Elective Care	CD General Surgery	1	1	0	
		CD T&O	1	1	0	
		CD Urology, ENT and	1	1	0	

Domain	Role		PA Required	PA Currently Funded	Investment Required	Comment
		Orthodontics				
	Emergency Medicine	CD CAH	1	1	0	
		CD DHH	1	1	0	
	ATICS	CD CAH	1	1	0	
		CD DHH	1	1	0	
		CD ICU	1	1	0	
	Medicine	CD CAH (Two Posts)	3	1	2	Additional Post (1.5PA per post)
		CD Cardiology	1	0	1	
		CD DHH	2	1	1	
	IMWH	CD CAH	1	1	0	
		CD DHH	1	1	0	
	CYPS	CD CAH	1	1	0	
		CD DHH	1	1	0	
		CD Comm Paeds	1	1	0	
		CD CAHMS	1	1	0	
	MHLD	CD Phys & Learning	1	1	0	
		CD Mental Health (Two Posts)	2	2	0	Being met with MHLD funds
		CD Psychiatry Old Age	1	1	0	

Domain	Role		PA Required	PA Currently Funded	Investment Required	Comment
	Cancer Services	CD Radiology	1	1	0	
		CD Laboratory	1	1	0	
		CD Cancer Services	1	1	0	
	Older People	CD Older People Community	1	1	0	
		CD Older People Stroke and Frailty	1	0	1	
Appraisal and Revalidation Support	Medical Lead Corporate Appraisal & Revalidation		1	1	0	
	Medical Lead Consultant Appraisal & Revalidation		1	1	0	
	Lead SAS Doctors Appraisal and Revalidation		2	2	0	*Two Existing Funded Posts*
	Appraiser Allocation (0.25PA per 8 appraisals per annum)		5	0	5	*Agreed as per LNC discussions 2019*
Patient Safety	Patient Safety Leads (M&M Chairs, 20 posts)		13.5	6	7.5	*Six posts Trustwide (7.5 new PA to include sub speciality and increase in support for CAH Medical M&M meetings)*
Total			**90.5**	**70.091**	**20.409**	

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director XXXXXXXXXXX

DIRECTORATE:

RESPONSIBLE TO: Service Director

ACCOUNTABLE TO: Medical Director

COMMITMENT: X PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DMD) will as a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative, have an active role in contributing to the strategic direction and the ongoing provision of high quality services which are safe and effective.

The DMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. Trust is firmly committed to embedding the “right culture” where everyone is committed to the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the “right” culture is underpinned by a collective leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DMD has a lead responsibility within the Division on the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance. In partnership with the Assistant Director and Professional Leads the DMD will also be

responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

1. To develop a culture of collective and compassionate leadership
2. To medically lead on all aspects of patient safety
3. To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control)	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement

4. To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
5. To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
6. To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture
7. To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.

8. To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
9. To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
10. To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
11. To actively contribute to the development and delivery of the Trust strategy and business plan.
12. To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:

    a) delivery of safe, high quality and effective person-centred care

    (b) secures activity and performance

    (c) maintains ongoing financial viability

    (d) is aligned to corporate goals.

    The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.

13. To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
14. To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
15. To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
16. To model the HSC values.
17. To act as an advocate for the Division.
18. To represent the Division at the relevant senior Trust meetings.
19. To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.

20. To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
21. Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
22. Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options

General Responsibilities

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
- The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

Adhere at all times to all Trust policies/codes of conduct, including for example:

- Smoke Free policy
- IT Security Policy and Code of Conduct
- standards of attendance, appearance and behaviour
- Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
- Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
- All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails.

All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Take responsibility for his/her own ongoing learning and development.
- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.
- This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.
- It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE: Associate Medical Director – Primary Care

DIRECTORATE: Older People & Primary Care

OPERATIONALLY RESPONSIBLE TO: Director of Older People & Primary Care

PROFESSIONALLY RESPONSIBLE TO: Medical Director

HOURS: 16 hours per week / 4 PAs

JOB SUMMARY

Be a member of the Directorate Senior Management team and play an active role in the provision of high quality services which are safe and effective. Provide a primary care perspective throughout the Southern Trust, working across all Directorates. Contribute to the development and implementation of services in line with the regional and Trust strategic direction.

- Provide expert advice to the Director of OPPC and Medical Director on matters relating to primary care provision.
- As part of the OPPC leadership team provide leadership and support on issues relating to primary care clinical and social care governance
- Design, develop and facilitate clinical governance interfaces between the Trust Southern Area General Practitioners that will facilitate timely information transfer regarding service provision, risk management and areas of concern
- To provide leadership to relevant medical staff in the Trust and promote the corporate values and culture of the Trust
- To provide leadership and professional support to the medical management team in the GP OOH service
- To take responsibility for performance management including appraisal of designated clinicians including completion of CP2A Forms where appropriate
- Enhance the relationship between primary and secondary care through partnership working to assist the Trust in the coproduction and redesign, modernisation and improvement of service delivery
- Promote effective communication between primary care and clinical/non clinical managers in the Trust to support team working
- Actively promote the development of clinical and professional networks between primary care and the Trust including GP Federations
- To provide leadership of GPs to enhance collaboration on Reform and Modernisation agenda

- Work with the Director of Older People and Primary Care to develop and maintain a regular forum or fora with GPs for discussion on strategic and operational issues and to be in a position to inform the Trust of primary care views on for example strategic change issues

As an Associate Medical Director – Primary Care, the jobholder will be a member of the directorate's senior management team and will contribute to policy development in all Trust directorates and support the achievement of overall objectives.

KEY RESPONSIBILITIES

Operational Leadership
Work with the wider Trust Management Teams to:

- Use the resources of the Directorate to deliver service improvement, in both quality and quantity, the activity, outcomes and targets agreed for the Directorate

- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated to maximise service provision and expand specific pathways of care

- Develop and maintain a regular forum or fora with GPs in order to discuss strategic and operational issues and to be in a position to inform the Trust of primary care views on strategic issues

- Actively promote the development of clinical and professional networks across primary, secondary and community care

- Develop systems to provide clinical information to staff to enable them to benchmark and audit their practice in order to develop innovative ways to deliver services and improve the patient experience.

- Be responsible for performance management, including appraisal and review of job plans, professional regulation for designated medical staff in the Directorate and to ensure that Personal Development Plans are in line with corporate objectives

- Provide clinical leadership in developing service improvement principles in response to specific access targets and ensure a focus on keeping the population well

Professional Leadership

- Develop and lead a team of primary care professionals to assist the Trust in redesign, modernisation and improvement of service delivery

- Identify and make provision for the training and development needs of designated medical staff in the Directorate and facilitate research activity in the Directorate

- To ensure the highest standards of clinical effectiveness in the Directorate, including the delivery of local and national recommendations including NICE guidelines, College guidelines or national reports

- Contribute as an effective member of Directorate Governance Committee

- Support the Trust to deliver on its quality and governance strategies through the promotion of a strong integrated governance approach in areas such as; professional regulation, dissemination of best evidence, data analytics and provision of information.

Strategic Leadership

- Function as a member of the Directorate Management Team with responsibility to contribute to strategic development as well as for operational excellence

- Advise the Management Team of Directorate priorities and pressures and be an active participant in Trust Delivery Plan negotiations.

- Provide advice in relation to postgraduate education within the service group.

- Support the Trust in planning a response to major incidents and outbreaks.

General Management Responsibilities

- Maintain good staff relationships and morale amongst the staff reporting to him/her.

- Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

- Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.

- Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

- Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Associate Medical Director – Primary Care works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Medical Director/ Director of Older People and Primary Care

General Requirements

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

- Adhere at all times to all Trust policies including for example:

    - Smoke Free policy
    - IT Security Policy and Code of Conduct

- Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

- Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

- All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

- Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE: Associate Medical Director – Primary Care

DIRECTORATE: Older People & Primary Care

Ref No: **73818054**

Salary: Annual Salary will be remunerated in line with Consultant Terms & Conditions, based on years' service as a GP

Responsibility allowance: 20% of the appointee's basic annual salary

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Hold a medical qualification, full GMC registration with licence to practice and must be on the GMC GP Register
2. Applicants must be on the NI GP Performers List
3. To have worked as a General Practitioner for a minimum of 3 years in the last 6 years
4. Demonstrate evidence of leadership within a team that led to successful service development and or quality improvement
5. Demonstrate evidence of having worked with a diverse range of stakeholders to achieve successful outcomes
6. Hold a full current driving license valid for use in the UK and have access to a car on appointment.[1]

[1] *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

The following are essential criteria which will be measured during the interview stage.

7. Excellent communication skills, both orally and in writing
8. Knowledge of formal appraisal in general practice
9. Commitment to provide 2 days (4 PAs) per week

Southern Health and Social Care Trust

Quality Care - for you, with you

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Medical Lead for Coroner Services (3 PA)
(1 Post, for 3 years in the first instance)

BASE:

DIRECTORATE:

RESPONSIBLE TO:

ACCOUNTABLE TO: Medical Director

JOB SUMMARY

The post-holder will work closely with the Trust's Litigation Manager and members of the Litigation Team to provide professional support and clinical input into the management of Coroner's cases.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within this role.

The post-holder will be required to adhere to Department of Health protocol / standards governing the Preparation for Coroner's Investigations / Inquests.

KEY RESPONSIBILITIES

Coroner's Services

- Ensure, in conjunction with the Litigation Manager, that there is a direct and efficient method of communication between the Trust and the Coroner's Office.

- Support the Litigation Manager, as appropriate, in identifying involved staff to provide statements, as requested by the Coroner's Office.

- In conjunction with the Litigation Manager, provide support to involved staff to ensure that they are clear about the role of the Coroner and their responsibilities to the Coroner's processes.

- Support the Litigation Manager, when required and in line with the Escalation Process, to ensure that statements are obtained from involved staff and forwarded to the Coroner within the required time-scales.

- Support the Litigation Manager, as required to obtain any other information requested by the Coroner to ensure that this is provided within a timely manner.

- Review, where appropriate, any independent expert reports, provided from the Coroner's Office; consider whether the Trust requires an expert report and notify the Litigation Manager on nominations for same.

- Liaise directly, as required, with the Trust's Legal Advisors (DLS).

- Obtain detailed information from the Litigation Manager on Coroner's cases, and when required, advise the Medical Director and the Medical Director's Office on matters relating to the Coroner's processes.

- In conjunction with the Litigation Manager, provide support and guidance to Trust staff involved in the coroner's process, and particularly those who are required to attend an Inquest Hearing. This may require your attendance at consultations with legal representatives and at Inquest Hearings.

- In conjunction with the Litigation Manager, ensure the dissemination of lessons learned from Coroner's processes, for action to be taken within the service areas. Ensure that any corporate lessons are highlighted to the Medical Director's Office.

Professional Practice

- Where there are professional medical issues identified as part of the Coroner's process that need to be addressed, advise the Medical Director and the Medical Director's Office in relation to this.

General Responsibilities

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

Adhere at all times to all Trust policies/codes of conduct, including for example:

- Smoke Free policy
- IT Security Policy and Code of Conduct
- standards of attendance, appearance and behaviour

- Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

- Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

- All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

- Take responsibility for his/her own ongoing learning and development.

- Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

- This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

- It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE Medical Lead for Coroners Services

DIRECTORATE

July 2019

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant or SAS doctor within the Southern Health and Social Care Trust.

2. Hold a medical qualification, and GMC registration

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS/INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Leadership Framework. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this framework to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. For ease of reference a copy of the Summary document on the NHS Leadership Framework is available with this advertisement. Further information may be obtained from www.nhsleadershipqualities.nhs.uk

The successful candidate will be appointed for a period of 6 months in the first instance subject to satisfactory performance.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

All staff are required to comply with the Trusts Smoke Free Policy

Southern Health and Social Care Trust

Quality Care - for you, with you

THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST ONLY

JOB DESCRIPTION

JOB TITLE: Medical Lead for Litigation Services (1 PA)
(1 Post, for 3 years in the first instance)

BASE:

DIRECTORATE:

RESPONSIBLE TO:

ACCOUNTABLE TO: Medical Director

JOB SUMMARY

The post-holder will provide professional support to the Trust's Litigation Team and work closely with the Litigation Manager, to ensure that clinical and social care claims are managed appropriately, and in accordance with the Trust's Procedure for the Management of Claims. Where required, the post-holder will also provide professional input to assist the Litigation Department's Medico-Legal Section in ensuring compliance with legislative time-scales associated with Subject Access Requests received from Solicitors, PSNI, Court Orders etc.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within this role.

KEY RESPONSIBILITIES

Setting Direction

- Contribute to the development of a Litigation Services Operational Plan, in conjunction with the Litigation Manager
- Provide support and direction to consultants and other medical staff on issues pertaining to claims against the Trust

Management of Clinical & Social Care Claims

- Meet regularly with the Litigation Manager to review claims activity and agree action to be taken with regards:-

  -New Claims

  -Claims where there have been significant developments

  -Claims that require additional support to progress / settle / close (who will have responsibility for admitting liability and agreeing to settle claims (currently the Medical Director).

- Support the Litigation Manager, when required, in the investigation of claims by obtaining involvement reports and relevant information from involved medical staff. This will enable decisions to be made about liability at an early stage in accordance with Pre-Action Protocol for Clinical and Social Care Negligence

- Work with involved clinicians, when required, to identify to the Litigation Manager in a timely manner nominations for independent expert reports to assist in the defence of a claim.

- Support the Litigation Manager, when required, in the management of claims by obtaining comments from relevant involved medical staff on legal documentation/experts reports etc, to enable the Trust to prepare a defence to claims received.

- Participate in monthly meetings with the Trust's Legal Advisors (DLS) to review claims, and liaise directly with DLS on specific claims, as required.

- Assist the Litigation Manager with issues that are escalated, to ensure progression of claims management, in line with required time-scales.

- In conjunction with the Litigation Manager, ensure the dissemination of lessons learned from litigation claims, for action to be taken within the service areas. Ensure that any corporate lessons are highlighted to the Medical Director's Office.

- When required, advise the Medical Director and the Medical Director's Office on claims related activity.

Medico-Legal Subject Access Requests

- Assist the Litigation Manager with issues that are escalated, to ensure that subject access requests / Court Orders are complied with, in line with legislative requirements.

Professional Practice

- In conjunction with the Litigation Manager, provide support and guidance to Trust staff involved in the claims process, and particularly those who are required to attend Court. This may require your attendance at legal consultations and at Court.
- Where there are professional medical issues identified via the management of a claim that needs to be addressed, advise the Medical Director and the Medical Director's Office in relation to this.

Collaborative Working

- Work closely with Associate Medical Directors, Clinical Directors, and medical staffing in relation to claims management and identify areas of concern / areas for improvement

Service Development & Improvement

- Regularly review claims activity data in conjunction with the Medical Director/Medical Director's Office/Litigation Manager to identify areas in which the service could be developed and improved.

General Responsibilities

The post holder will be required to:

- Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

- Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

- The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and