~~23.~~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 HSC organisation may use "gardening leave" as a means of resolving a problem covered by this framework.**

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Existing suspensions & transitional arrangements

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

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

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

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

Regular review

27. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[14]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

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

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

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to CE and Medical Director. • Each review is a formal matter and must be documented as such. • The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: • A report must be made by the Medical Director to the CE: - outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed - a timetable for completion of the investigation. • The CE must report to the Director of Human Resources at the Department, who will involve the

	CMO if appropriate. • The case must be formally referred back to the NCAS explaining: - why continued exclusion is thought to be appropriate; - what steps are being taken to complete the investigation at the earliest opportunity. • The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, • A further position report must be made by the CE to the Department indicating: - the reason for continuing the exclusion; - anticipated time scale for completing the process; - actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

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

The role of the Department in monitoring exclusions

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

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

RETURN TO WORK

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

APPENDIX 2 ~~SECTION III.~~ GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

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

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

3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation. [15]

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

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

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

CODES OF CONDUCT

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

- a refusal to comply with the requirements of the employer where these are shown to be reasonable;
- an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of doctors and dentists by their regulatory body[16];
- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

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

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

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

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

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

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

11. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.? Check accuracy of reference

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

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

Dropping of charges or no court conviction

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

APPENDIX 3 ~~SECTION IV~~ PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

INTRODUCTION & GENERAL PRINCIPLES

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

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

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

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

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

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

How to proceed where conduct and clinical performance issues are involved

5. It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[17].

7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has

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

been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

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

HEARING PROCEDURE

The pre-hearing process

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

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;
- all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing;
- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at

least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;

- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;
- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.[18] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

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

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

- a senior member of staff from Human Resources;
- an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HSC employer;
- a representative of a university if provided for in any protocol agreed between the employer and the university.

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

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

Representation at clinical performance hearings

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

14. The practitioner may be represented in the process by a companion who may be another employee of the HSC body: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be

representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the clinical performance hearing

15. The hearing should be conducted as follows:

- the panel and its advisers, the practitioner, his or her representative and the Case Manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- the Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
- the procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:
- the witness to confirm any written statement and give any supplementary evidence;
- the side calling the witness can question the witness;
- the other side can then question the witness;
- the panel may question the witness;
- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

- the Case Manager presents the management case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;
- the Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification;

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

Decisions

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

Possible decisions made by the clinical performance panel

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;
- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:
  - the clinical performance problem(s) identified;
  - the improvement that is required;
  - the timescale for achieving this improvement;
  - a review date;
  - measures of support the employer will provide; and

- the consequences of the practitioner not meeting these requirements.

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

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

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

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

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

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

19. The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be

addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

Introduction

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

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

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

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

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

The appeal process

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

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

The appeal panel

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

<u>Membership of the appeal panel</u>

- an independent member (trained in legal aspects of appeals) from an approved pool.[19] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing

[19] See Annex A.

organisation who must have the appropriate training for hearing an appeal;

- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[20] who must also have the appropriate training for hearing an appeal.

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

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

- a consultant from the same specialty or subspecialty as the appellant, but from another HSC/NHS employer [21];
- a senior Human Resources specialist.

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

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

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

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

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

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

Powers of the appeal panel

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

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

32. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider

the new evidence as relevant to the appeal, or whether the case should be re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

Conduct of appeal hearing

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

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

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

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

Decision

37. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's Case Manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision

of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

Action following hearing

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

Annex A

APPEAL PANELS IN CLINICAL PERFORMANCE CASES

Introduction

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

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

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

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

Creating and administering the list

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

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

6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn

up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

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

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

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

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

INTRODUCTION

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

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

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

HANDLING HEALTH ISSUES

4. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation

(where appropriate)[19]. The practitioner may be accompanied to these meetings (as defined in Section I, para 30). Confidentiality must be maintained by all parties at all times.

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

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

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

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

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

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

Examples of action to take

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

DISABILITY DISCRIMINATION ACT (DDA)

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

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

examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

Examples of reasonable adjustment

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

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

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

Maintaining High Professional Standards In the 21st Century

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

Department of Health, Social Services & Public Safety
October 2011

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21st CENTURY

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

TABLE OF CONTENTS:

INTRODUCTION

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

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

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

4. This framework is in 5 sections and covers:

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

Background

5. The delivery of safe, effective and high quality care to patients and service users is the priority of every HSC organisation in Northern Ireland. The vast majority of patients receive this standard of care, delivered by healthcare

professionals who are up to date, fit to practise and demonstrate commitment to providing excellent healthcare.

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

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

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

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

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

(i) identifying issues,

(ii) investigation,

(iii) deciding on what action is needed and

(iv) access (where appropriate) to remediation.

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

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

12. This guidance is applicable to all doctors and dentists employed by one of the five Health and Social Care Trusts, the Health and Social Care Board, Public Health Agency, the NI Ambulance Trust and the NI Blood Transfusion Service.

~~Concerns about~~

13. Concerns in relation to the performance of doctors and dentists in training should be managed ~~handled~~ by employers in line with those for other medical

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_06946

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

and dental ~~staff~~ staff. It is, however, essential that ~~with the proviso that the~~ Postgraduate ~~Dean~~Dean, as Responsible Officer for doctors in training, ~~should~~ is~~be~~ involved in these ~~appropriate~~ cases **from the outset**. The onus still rests with the employer for the conduct of the investigation and any necessary action.

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

SECTION 1- STRATEGIC AND REGIONAL CONTEXT OF THIS FRAMEWORK

~~12.~~15. Since 2005 there has been significant restructuring in the HSC, along with proposals for new regulatory arrangements for doctors and dentists. This, along with the experience gained through implementing the 2005 guidance and procedures of MHPS, has necessitated this revision of the framework.

HSCNI GOVERNANCE AND ACCOUNTABILITY

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

~~HSCNI GOVERNANCE AND ACCOUNTABILITY~~

~~13.~~17. As their sponsor, the DHSSPS holds all HSC Bodies directly to account for their good governance responsibilities. This accountability runs through the Minister to the Assembly and its committees.

~~14.~~18. Those responsible within HSC organisations for the implementation of the processes in this framework should be aware of these regional accountability arrangements and ensure that when managing concerns in relation to doctors or dentists, the assessment of risk to patient or public health and wellbeing includes consideration of the need to escalate concerns to the appropriate HSC Body.

PROFESSIONAL REGULATION OF DOCTORS AND DENTISTS

~~15.~~19. The implementation of the processes described in this document should also include consideration of the need to refer the practitioner to their professional regulatory body, for dentists, the General Dental Council (GDC) and for doctors, the General Medical Council (GMC). Referrals made under fitness to practice proceedings should be made promptly where there is information available that indicates this is necessary. Guidance on areas the GDC consider for investigation can be found on their website[3] and the GMC have published referral thresholds for doctors, which can also be accessed via their website[4].

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

REVALIDATION

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

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

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

~~16.~~22.

MEDICAL REVALIDATION AND THE RESPONSIBLE OFFICER

~~17.~~23. The GMC will implement a system of revalidation for it's registrants in late 2012. All registrants who required a Licence to Practise or who sought one in 2009 have been issued with one from the GMC. Renewal of this licence will be subject to the process of revalidation whereby a senior doctor in a healthcare organisation, known as a Responsible Officer (RO), will make a recommendation to the GMC that those doctors with whom they have a prescribed relationship should be revalidated.

~~18.~~24. Legislation, (and supporting Guidance)[5] to require all designated organisations to appoint or nominate a Responsible Officer came into operation in Northern Ireland on 1st October 2010. The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010[6] identify the five HSC Trusts, and the NI Ambulance Service Trust, as being designated organisations, the Medical Director of each is now the appointed Responsible Officer. The Northern Ireland Medical and Dental Training Agency is also a designated organisation, making the post-graduate Dean the Responsible Officer for doctors in training.

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

a. To ensure that regular appraisals are undertaken

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

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

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

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

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

REVALIDATION FOR DENTISTS

22 The General Dental Council (GDC) recently consulted on their proposals for the revalidation of dentists. The proposed framework comprises of a five year cycle, at the end of which dentists will be required to demonstrate compliance with standards set by the GDC. External verifiers will be established and they will be required to review the supporting evidence submitted by dentists and certify the individual's compliance with the Standards.

REVALIDATION AND MANANGING CONCERNS

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

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

25 The processes upon which revalidation will be based, namely annual appraisal and review of information generated by the organisation in relation to the practitioner's performance, may highlight the presence of a concern at an earlier stage. The processes in place to manage identified concerns as described in this Framework will not change as revalidation is introduced.

However, the potential identification of concerns at an earlier stage could allow for earlier intervention and remediation (where appropriate). This will allow practitioners opportunity to address the area/s identified and provide opportunity for these to be improved on wherever possible.

SECTION 2 IDENTIFYING CONCERNS

HOW CONCERNS ARE IDENTIFIED

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

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

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

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

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

~~28~~ Concerns raised about a colleague must be based on concern for patient welfare. Individual practitioners should be protected from unfounded or malicious allegations which can cause lasting damage to their reputation and career. Where allegations raised by a fellow HSC employee are shown to be malicious, that employee should themselves be subject to the relevant disciplinary procedures. All HSC organisations are required to ensure that they have a *Whistle Blowing* Policy and should ensure that every effort is made to support the employee who has raised the concern.

29

~~31.~~29. All professional regulatory bodies define standards of practice they expect from their registrants, which include the requirement to take action if they perceive a risk to patient safety. Thus, there is an additional burden on health care staff subject to statutory regulation to report concerns.

~~32.~~30. There is also a need to ensure lessons are learnt from previously high profile cases where concerns relating to practitioners were widely known by other healthcare professionals but not formally articulated, often resulting in harm to patients. The failure to recognise the significance of concerns expressed, coupled with the failure of different organisations to combine the information they held are discussed in the DH Report *Learning from Tragedy*[7] (2007) , which details the action programme in response to the Shipman inquires and lessons learnt the Ayling and Kerr/Haslam cases.

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

31. It should be noted that 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.

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

SUMMARY OF KEY ACTIONS NEEDED WHEN A CONCERN ARISES

~~32.~~33. When a concern is raised, and throughout the resulting processes, consideration of the concern and action needed should be given equal consideration to patient safety. As such, the key actions needed at the outset can be summarised as follows:

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

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PROTECTING PATIENTS AND THE PUBLIC

~~33.~~34. A risk assessment should be undertaken when a concern is identified to ensure the continued safety of patients and the public. This risk assessment should be reviewed regularly during the investigatory process and rationale for decisions made documented. Excluding the practitioner from the workplace may be unavoidable; however it should not be the only or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:

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

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

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SECTION 3: INVESTIGATION

~~34.~~36. This section outlines the key principles and best practice in undertaking an investigation of a concern. Actions that may be taken as a result of the investigation are described in Section 3 of this framework.

~~35.~~37. Good practice in carrying out investigations of concerns can be summerised in the following principles, ~~detailed in the Tackling Concerns Locally Report~~[8]:

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

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

UNDERTAKING AN INVESTIGATION

~~36.~~38. This revised framework identifies a two stage investigatory approach (previously referred to as 'informal' and formal' investigations) when a concern is raised. The first stage comprises a preliminary investigation and the second stage (if required), an extended investigation. Actions that may be taken during and on completion of each stage of the investigation are described in paragraph X of this framework.

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~~37.~~39. It should be noted that if ~~where~~ the practitioner is the subject of an ongoing investigation by the Police, Counter Fraud Unit or a regulatory or licensing body ~~then~~ , this does not necessarily prevent an ~~local~~ investigation into unrelated matters taking place. It would however, be advisable to consult the relevant organisation before commencing any ~~local i~~investigation, for example the GMC's ELAs. Where an ~~local~~ investigation is has been commenced ~~already underway~~ and the ~~local~~ organisation becomes aware of another investigation, ~~then again~~ liaison with the relevant body should take place.

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~~38.~~40. The purpose of conducting any investigation is to inform a decision making process that will identify what, if any, action needs to be taken to address the concern. The importance of the investigation should not be underestimated as the concepts of procedural and substantive fairness apply as much to the conduct of the investigation as the decision that results from it.

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~~39.~~41. The following principles, as defined by the Labour Relations Agency resource *Advice on Conducting Employment Investigations* (INSERT REFERENCE) provide a valuable resource ~~starting point~~ for the investigatory process that apply at any stage:

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- ***Why is the investigation necessary?***
  The application of a process of investigation demonstrates the organisation has a consistently applied, fair approach to investigating concerns

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

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

- ***When and Where?***
  The investigation should commence as soon as possible when a concern has been identified. Where there are identified timescales, the organisation should adhere to these to maintain momentum but should have a defined process to extend the timescales under exceptional circumstances. In all cases the investigation should proceed as quickly as possible and any delays accounted for. There should be a defined timescale for notice given to the subject of the investigation to attend an interview and consideration should be given to the most appropriate setting for an interview.

COLLECTING EVIDENCE

~~40.~~42. The investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter. The investigator should therefore take account of positive indicators as well as any negative indicators and any relevant national or local benchmarks.

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~~41.~~43. It is important that the investigation collects all the evidence that may be available relating to the concerns or allegations being made. This will involve interviewing all those who may be able to provide information and making a careful note of their evidence. Where possible and depending on the circumstances, this will include patients, their relatives and the practitioner concerned.

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~~42.~~44. If any case is to proceed, evidence has to be demonstrated, whether to the HSC Trust Board, the Tribunal, the GMC or in the courts. While the rules of evidence can become complicated, there are some simple questions that should always be asked:

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

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

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

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

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

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

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

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

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

STAGE 1-PRELIMINARY INVESTIGATION

~~43.~~45. The investigatory process should commence with a preliminary investigation to identify the issues surrounding the concern that has been identified. This first stage should take account of the evidence to hand, alongside any comments the practitioner wishes to make, and should provide an indication of the substance of the concern and the most appropriate course of action.

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~~44.~~46. The Clinical Director, Human Resources Director, and Medical Director/Responsible Officer should be informed of the investigation. They may decide to inform the Chief Executive and/or Executive Board at this stage if there is an apparent risk to patient safety, and/or for reputational damage to the organisation:

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~~45.~~47. The preliminary investigation should be appropriately documented, resourced and recorded from the outset. If further investigation is required, the methodology and findings from the preliminary investigation will be critical in establishing the terms of reference of an extended investigation. Robust recording will also provide assurance to the organisation that the appropriate process has been followed and how decisions were reached.

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~~46.~~48. The preliminary investigation should be undertaken by a senior clinician in the HSC organisation and should include:

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- Review of relevant clinical or administrative records

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

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

~~47.~~49. The preliminary investigation should be completed as quickly as possible. The practitioner who is the subject of the investigation should always be given the opportunity to comment on the issues as identified ~~at the end of~~throughout the investigation. Their comments must be taken into consideration before any decision is reached in relation to any subsequent action.

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

STAGE 2: EXTENDED INVESTIGATION

~~48.~~50. Where it has been established~~s~~ decided that an extended investigation should ~~needs to~~ be undertaken, that has the potential to lead to conduct or clinical performance proceedings, the CE must, after discussion between the Responsible Officer/Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.

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Commented [JL9]: ? Threshold criteria for formal/ informal proceedings

~~49.~~51. At any stage of this process, or subsequent disciplinary action, the practitioner may be accompanied to any interview or hearing by a companion. The companion may be another employee of the HSC body; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

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~~50.~~52. The investigatory approach described in paragraphs 34-42 of this document apply to both preliminary and extended investigations.

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TRAINING

~~51.~~53. Employers must ensure that managers and Case Investigators receive appropriate training in the operation of performance procedures. Those undertaking investigations or sitting on disciplinary or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members have completed before they can take a part in these proceedings.

DEFINITION OF ROLES

~~52.~~54. The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board should only be sufficient to enable the board to satisfy itself that the procedures are being followed. Only the "designated Board member "should be involved to any significant degree in the management of individual cases.

~~53.~~55. The key individuals that may have a role in the process are summarised below:-

a. Chief Executive (CE) – all concerns must be registered with the CE who, should an extended investigation be required, must ensure that the following individuals are appointed;

b. the "designated Board member" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion or any representations about the investigation;

c. Case Manager – this is the individual who will lead the extended investigation. The Medical Director/Responsible Officer will normally act as the case manager but he/she may delegate this role to a senior

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Commented [PW10]: On reflection might be better to describe the process and then see whether there remains a need to define all these roles.

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medically qualified manager in appropriate cases. If the Medical Director / Responsible Officer is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;

d. Case Investigator – this is the individual who will carry out the extended investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director/Responsible Officer and Director of HR and should, where possible, be medically qualified;

e. the Director of HR's role will be to support the Chief Executive and the Medical Director/Responsible Officer.

OUTLINE OF RESPONSIBILITIES

The Case Investigator:

- must formally, on the advice of the Medical Director/Responsible Officer, involve a senior member of the medical or dental staff[9] with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;

- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not

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

covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;

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

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

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

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

The Case Manager's Role:

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

- The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the

Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied.

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

Timescale and decision

~~54.~~56. The Case Investigator should, other than in exceptional circumstances, aim to complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. The Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

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~~55.~~57. The report should give the Case Manager sufficient information to make a decision on whether:

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- no further action is needed;
- restrictions on practice or exclusion from work should be considered;

- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSC body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by the NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC; there are intractable problems and the matter should be put before a clinical performance panel.

~~56.~~58. Formal processes are illustrated in the diagram on page 42.

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~~HANDLING OF ILLNESS ARISING DURING EXTENDED INVESTIGATION~~

~~57.If an excluded employee or an employee facing any process in Stage 2 of this framework becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside these processes and the employer should take reasonable steps to give the employee time to recover and attend any hearing.~~

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~~58.Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.~~

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~~59.If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill health, the practitioner should have the opportunity to provide written submissions and/or have a representative attend in his absence.~~

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~~60.~~59. Where a case involves allegations of abuse against a child or a vulnerable adult, the guidance issued to the HSCNI in 2006- Safeguarding Vulnerable Adults and the revised framework Choosing to Protect Children and Vulnerable Adults 2009. Check ref to Guidance [10]INSERT FOOTNOTE TO GUIDANCE – check below is correct

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

PROCESS FOR SMALLER ORGANISATIONS

~~61.~~60. Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

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~~62.~~61. Such organisations should consider working in collaboration with other local HSC organisations (e.g. other Trusts) in order to provide sufficient personnel to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HSC organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

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TERMINATION OF EMPLOYMENT WITH PROCEDURES INCOMPLETE

~~63.~~62. Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

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~~64.~~63. There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

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~~65.~~64. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning). CONFIRM THIS IS STILL CORRECT TITLE ?ISA

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GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

~~66.~~65. 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:

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

CONFIDENTIALITY

~~67.~~66. Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any

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investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

~~68.~~67. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

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~~TRANSITIONAL ARRANGEMENTS~~

~~69.On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.~~

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SECTION 4 OPTIONS FOLLOWING INVESTIGATION

~~70.~~68. This section outlines the key principles in relation to decision making following an investigation and the range of measures that may be taken to manage the concern while ensuring patient safety.

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THE DECISION MAKING PROCESS

~~71.~~69. Once the investigation has established the facts, an entirely separate process is needed to decide what action (if any) is needed. Key principles in relation to decision making can be summarised as follows:

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- A decision must be made, recorded and all relevant parties informed
- There should be complete separation between the investigation and decision making process
- The decision making process must be seen to be fair, impartial, consistent and timely
- Expert input should be sought where necessary
- A range of options should be considered based on the circumstances of the individual doctor or dentist
- Organisations should consider their own learning and make appropriate changes
- Individuals should be seek out support
- The doctor or dentists should have the right to appeal against any decisions made, except for decisions to refer cases to the regulator, to the police or to the counter fraud unit.

OPTIONS FOLLOWING PRELIMINARY INVESTIGATION

~~72.~~70. At the conclusion of the preliminary investigation, the information collated should be reviewed and a decision made in relation to what, if any, next steps should be taken. As a first step, this preliminary investigation is

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essential to verify or refute the substance and accuracy of any concerns or complaints. This is a difficult decision and should not be taken alone but in consultation with the Responsible Officer, Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

~~73.~~71. At this stage of the investigatory process a range of options are available to organisations. These options are not mutually exclusive - patient protection and action required to manage the concern may require implementation of one or more of the following :

- No action to be taken
- Remedial action required
- Measures to ensure patient safety required – restriction on practice or exclusion
- Local process agreed with the practitioner to be implemented
- Proceed to Stage 2- Extended Investigation

NO ACTION REQUIRED

~~74.~~72. If, at the conclusion of the preliminary investigation, it has been agreed that no action is required, the practitioner should be informed of this decision as soon as possible. The record of the investigation should be completed and include the rationale for the decision. This record should be held on the practitioner's personnel file for future record. CHECK POLICY

REMEDIAL ACTION REQUIRED

~~75.~~73. If the outcome of the preliminary investigation is the identification of a performance concern (as per definition in paragraph 2 of this Framework- referring to all aspects of a practitioner's work including conduct, health and clinical performance), consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The

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NCAS can advise on the practicality of this approach. Paragraphs 207-215 of this paper outline the service provided by NCAS.

MEASURES TO ENSURE PATIENT SAFETY

RESTRICTIONS ON PRACTICE

~~76.~~74. When significant issues relating to performance are identified at any stage of the processes described in this framework which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties and obtain relevant undertakings e.g. regarding practice outside the organisation in another HSC organisation or private practice. Any restrictions on practice must be an interim measure and should be documented and kept under review during the investigatory process.

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IMMEDIATE EXCLUSION

~~77.~~75. An immediate time limited exclusion from the workplace may be necessary to protect the interests of patients or other staff; or where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

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~~78.~~76. The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a [redacted] and to convene a case conference involving the clinical manager, the Medical Director/Responsible Officer and appropriate representation from Human Resources.

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~~79.~~77. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director/Responsible Officer and the Clinical

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Directors for staff below the grade of consultant. For consultants it should include the CE and Responsible Officer /Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

~~80.~~78. The clinical manager, having obtained the authority to exclude, must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting.

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~~81.~~79. Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

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~~82.~~80. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

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~~83.~~81. The 4 week exclusion period should allow sufficient time for initial or further investigation to determine a clear course of action, including the need for formal exclusion, remediation, disciplinary action and/or referral to the regulator.

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~~84.~~82. At any point in the process where the Medical Director/Responsible Officer has reached a decision that a practitioner is to be the subject of exclusion, the regulatory body should be notified. Users of this Framework should refer to the DHSSPS Guidance Issuing Alert Letters (circular HSS (TC8) (6)/98) and Guidance on Information Sharing to Provide Assurance.

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~~85.~~83. Paragraphs 109-130 of this framework set out the procedures to be followed should an extended investigation indicate that a longer period of formal exclusion is required.

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~~86.~~84. The following diagram provides an overview of the informal process.

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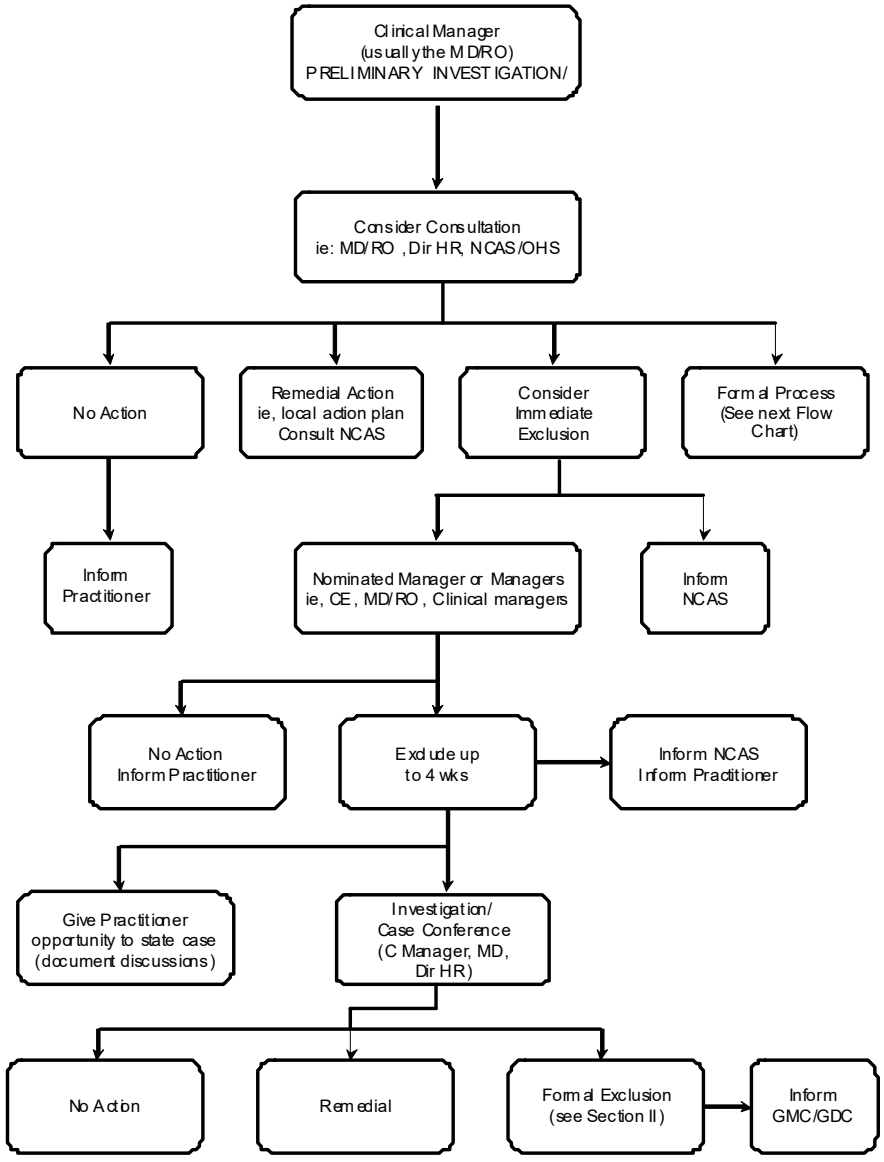
INFORMAL PROCESS



OPTIONS FOLLOWING EXTENDED INVESTIGATION.

~~87.~~85. Options following an extended investigation are described in this section. As per options following a preliminary investigation, these are not mutually exclusive and ensuring patient and public safety, and action required to manage the concern may require implementation of one or more of the following :

- No further action
- Referral to OHS
- Measures to protect patients - restriction of practice & exclusion from work
- Conduct panel
- Clinical Performance Panel
- Referral to GMC/GDC
- Referral to the NCAS.

NO FURTHER ACTION

~~88.~~86. If, at the conclusion of an extended investigation, it has been agreed that no further action is required, the practitioner should be informed of this decision as soon as possible. The investigatory record should be completed and include the rationale for this decision. This record should be held on the practitioner's personnel file for future record.

REFERAL TO OCCUPATIONAL HEATH SERVICE

~~89.~~87. When the findings of an extended investigation demonstrate there are concerns about the practitioner's health that should be considered by the HSC body's Occupational Health Service (OHS) and the findings reported to the employer.

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~~90.~~88. In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.

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~~91.~~89. The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HSC.

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HANDLING HEALTH ISSUES

~~92.~~90. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director/Responsible Officer and a meeting should be convened with the Director of HR, the Medical Director/Responsible Officer or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)[11]. The practitioner may be accompanied to these meetings (as defined in paragraph 49). Confidentiality must be maintained by all parties at all times.

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~~93.~~91. The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.

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~~94.~~92. In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary

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

procedures or misconduct procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

~~95.~~93. A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

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RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

~~96.~~94. Wherever possible the organisation should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of action that may be taken in these circumstances, in consultation with OHS and having taken advice from NCAS and/or NIMDTA if appropriate.

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~~97.~~95. Examples of action to take:

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

DISABILITY DISCRIMINATION ACT (DDA)

~~98.~~96. Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.

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~~99.~~97. Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non - disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

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~~100.~~98. Examples of reasonable adjustment

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- 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.

~~101.~~99. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and HSC Superannuation Branch.

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~~102.~~100. Note. Special Professional Panels (generally referred to as the "three wise men") were set up under circular TC8 1/84. This part of the framework replaces those arrangements and any existing panels should be disbanded.

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MEASURES TO PROTECT PATIENTS:
RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK

~~103.~~101. This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.

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~~104.~~102. In this part of the framework, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

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~~105.~~103. The Directions require that HSC bodies must ensure that:

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

MANAGING THE RISK TO PATIENTS

~~106.~~104. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.

~~107.~~105. 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.

~~108.~~106. It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

~~109.~~107. **Under the Directions, an HSC body cannot require the exclusion of a practitioner for more than four weeks at a time.** The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key aspects of exclusion from work

~~110.~~108. Key aspects include:

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- an initial "immediate" exclusion of no more than four weeks if warranted as set out in paragraphs 77-84
- notification of the NCAS before immediate and formal exclusion;
- formal exclusion (if necessary) for periods up to four weeks;
- ongoing advice on the case management plan from the NCAS;
- appointment of a designated Board member to monitor the exclusion and subsequent action;
- referral to NCAS for formal assessment, if part of case management plan;
- active review by clinical and case managers to decide renewal or cessation of exclusion;
- a right to return to work if review not carried out;
- performance reporting on the management of the case;
- programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
- a right for the doctor to make representation to the designated Board member

~~111.~~109. The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director/Responsible Officer and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director/Responsible Officer.

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Exclusion other than immediate exclusion

~~112.~~110. A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether

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there is reasonable and proper cause to exclude. The NCAS must be consulted where formal exclusion is being considered. If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.

~~113.~~111. The report should provide sufficient information for a decision to be made as to whether: Formatted: Bullets and Numbering

(i) the allegation appears unfounded; or
(ii) there is a misconduct issue; or
(iii) there is a concern about the practitioner's clinical performance; or
(iv) the complexity of the case warrants further detailed investigation before advice can be given.

~~114.~~112. Formal exclusion of one or more clinicians must only be used where: Formatted: Bullets and Numbering

a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of allegations of misconduct; concerns around the functioning of a clinical team which are likely to adversely affect patients; or concerns about poor clinical performance;

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

~~115.~~113. Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case. Formatted: Bullets and Numbering

~~116.~~114. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the Formatted: Bullets and Numbering

reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion (paragraph 49 defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

~~117.~~115. The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 121, and the need to remain available for work paragraph 122) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

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~~118.~~116. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

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~~119.~~117. If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.

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~~120.~~118. If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

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Exclusion from premises

~~121.~~119. Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff

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Keeping in contact and availability for work

~~122.~~120. Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HSC employer. This caveat does not refer to time for which they are not being paid by the HSC employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified

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because the practitioner is no longer available for work (e.g. abroad without agreement).

~~123.~~121. The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

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Informing other organisations

~~124.~~122. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HSC and non-HSC) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HSC employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer[12] Ref Information Sharing Guidance

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~~125.~~123. Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HSC, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.

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

~~126.~~124. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been commonly used in the recent past. No HSC organisation may use "gardening leave" as a means of resolving a problem covered by this framework.

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Existing suspensions & transitional arrangements

~~127.~~125. On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

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KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

~~128.~~126. 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:

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

Regular review

~~129.~~127. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[13]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

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~~130.~~128. The HSC body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

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

EXCLUSION REVIEWS

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. Case Manager submits advisory report of outcome to CE and Medical Director. Each review is a formal matter and must be documented as such. The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: A report must be made by the Medical Director to the CE: outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed

	a timetable for completion of the investigation. The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. The case must be formally referred back to the NCAS explaining: why continued exclusion is thought to be appropriate; what steps are being taken to complete the investigation at the earliest opportunity. The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, A further position report must be made by the CE to the Department indicating: the reason for continuing the exclusion; anticipated time scale for completing the process; actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

~~131.~~129. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

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The role of the Department in monitoring exclusions

~~132.~~130. When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.

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~~133.~~131. When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

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RETURN TO WORK

~~134.~~132. If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

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CONDUCT HEARINGS AND DISCIPLINARY PROCESSES

~~135.~~133. When the outcome of an extended investigation shows that there is a case of misconduct, this must be put to a conduct panel. Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.

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~~136.~~134. It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraphs 149-204 refer).

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~~137.~~135. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation[14].

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~~138.~~136. Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.

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~~139.~~137. HSC bodies must work in partnership with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

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

CODES OF CONDUCT

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

(i) a refusal to comply with the requirements of the employer where these are shown to be reasonable;
(ii) an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of doctors and dentists by their regulatory body[15];
(iii) the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
(iv) wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

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

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

of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.

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

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

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

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

145 Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.? Check accuracy of reference

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

146 There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made.

147 Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

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

CLINICAL PERFORMANCE PANEL

INTRODUCTION & GENERAL PRINCIPLES

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

150 Concerns about the clinical performance of a doctor or dentist may arise as outlined in paragraphs 26-27. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through agreed local processes set out in Section I (paragraphs 15 – 17) the matter must be referred to the NCAS before consideration by a performance panel (unless the practitioner refuses to have his or her case referred).

151 Matters which may fall under the performance procedures include: outdated clinical practice;

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

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

153 Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in paragraphs 57-60.

How to proceed where conduct and clinical performance issues are involved

154 It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

155 The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[16].

156 As set out in paragraphs 207-215, the NCAS can assist the employer to develop an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the

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

employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

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

HEARING PROCEDURE

The pre-hearing process

158 The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;

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

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;

- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;

- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.

- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

159 The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately

experienced medical or dental practitioner who is not employed by the Trust.[17] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

160 Arrangements must be made for the panel to be advised by:

- a senior member of staff from Human Resources;
- an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HSC employer;
- a representative of a university if provided for in any protocol agreed between the employer and the university.

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

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

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

Representation at clinical performance hearings

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

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

Conduct of the clinical performance hearing

165 The hearing should be conducted as follows:

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

- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

166 The order of presentation shall be:

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

Decisions

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

Possible decisions made by the clinical performance panel:

a. a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;

b. a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

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

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

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

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

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

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

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

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

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

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

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

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

176 It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 177 below).

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

The appeal process

178 The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is

re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.

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

The appeal panel

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

- an independent member (trained in legal aspects of appeals) from an approved pool.[18] 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[19] who must also have the appropriate training for hearing an appeal.

[18] See Annex A.
[19] Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.

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

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

- a consultant from the same specialty or subspecialty as the appellant, but from another HSC/NHS employer[20];
- a senior Human Resources specialist.

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

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

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

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

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

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

Powers of the appeal panel

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

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

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

Conduct of appeal hearing

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

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

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

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

Decision

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

Action following hearing

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

APPEAL PANELS IN CLINICAL PERFORMANCE CASES update section

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

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

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

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

Creating and administering the list

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

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

201 The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the Judicial Studies Board. The framework, which can be adapted to suit particular circumstances sets out six headline competencies

featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

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

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

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

REFERRAL TO PROFESSIONAL REGULATOR

205 During the processes described in this framework, reference is made at key stages at which referral to the practitioner's professional regulator should be considered. These include:

- When a finding of misconduct has been upheld
- When a finding of unsatisfactory clinical performance has been reached.

206 Threshold criteria for referral under fitness to practice proceedings are referenced in paragraph 17 of this framework.

REFERRAL TO THE NCAS

207 The NCAS is a division of the NHS Patient Safety Agency and was established to assist healthcare managers and practitioners to understand, manage and prevent performance concerns.

208 At any stage in the handling of a case consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSC Trusts and practitioners. This includes:

- immediate telephone advice, available 24 hours;
- advice, then detailed supported local case management;
- advice, then detailed NCAS performance assessment;
- support with implementation of recommendations arising from assessment.

209 Employers or practitioners are at liberty to make use of the services of the NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in paragraphs 77-84 and 109-130 of this framework.

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

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

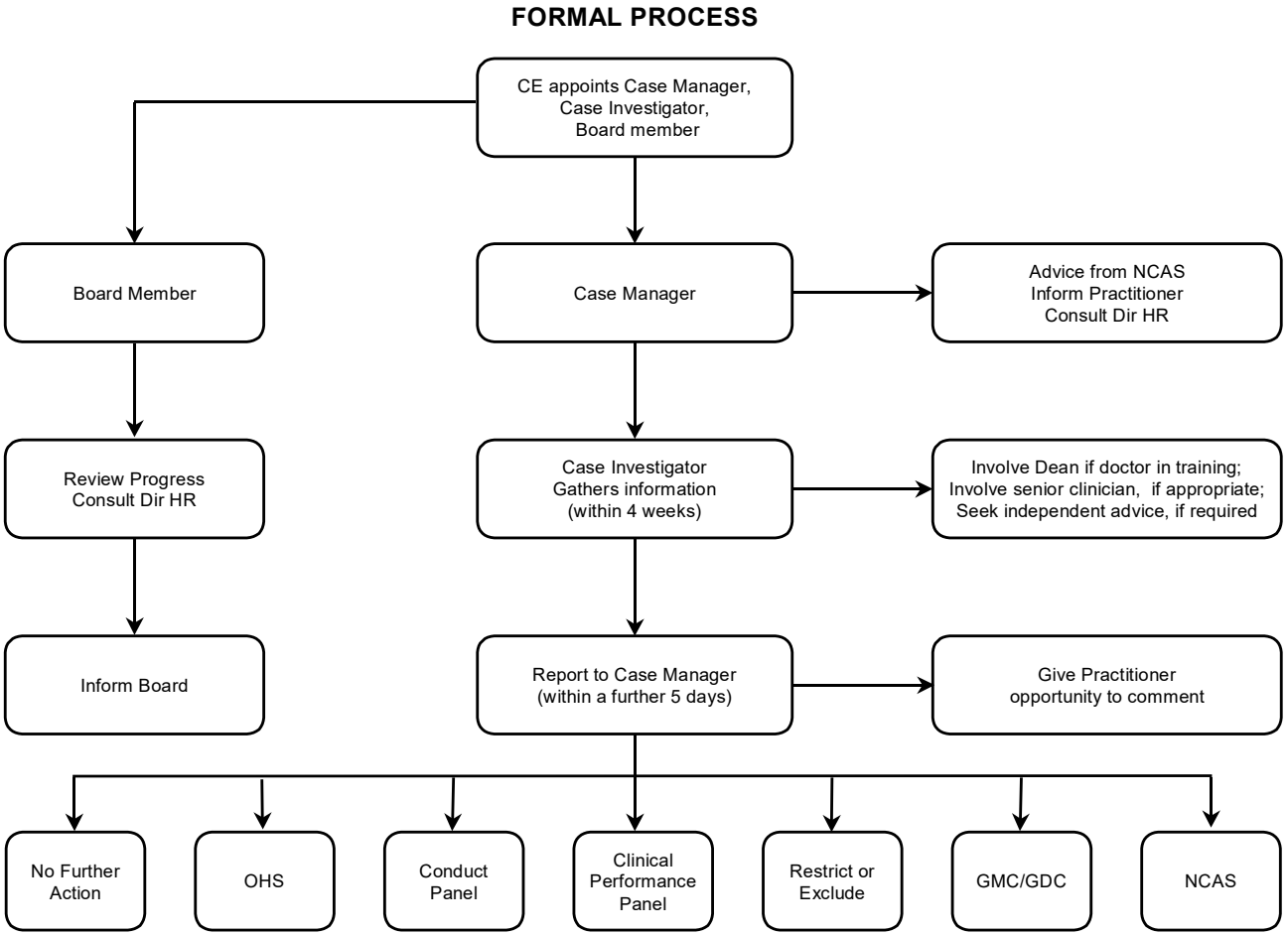
- clinical performance falling well short of recognised standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are ongoing or recurrent.

212 A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HSC or private sector other than their main place of HSC employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals in its Handbook. 21. See also circular HSS (TC8) 5/04.

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

214 The local action plan should be agreed by both the practitioner and a senior clinician in the organisation. A timescale should be defined for review and completion of the objectives of the action plan and progress documented.

215 Successful completion of the action plan should be documented and this information retained in the practitioner's personnel file



HANDLING OF ILLNESS ARISING DURING EXTENDED INVESTIGATION

138. If an excluded employee or an employee facing any process in Stage 2 of this framework becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside these processes and the employer should take reasonable steps to give the employee time to recover and attend any hearing.

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139. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

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

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Appendix 1 – Glossary

Roberts, Naomi

From: Lindsay, Jane
Sent: 09 September 2011 12:47
To: O'Carolan, Donncha
Cc: Woods, Paddy; Cairns, Joyce; Hutchison, Ruth
Subject: Confidence in Care Revised Documentation

Donncha,

You will be aware that the CiC Programme have been undertaking a revision of *Maintaining High Professional Standards for Doctors and Dentists (MHPS)* . The working draft revision, now titled *Maintaining High Professional Standards in the 21st Century* is attached for your consideration.

We intend to form a small, short-life working group comprising an HSC Medical Director, Human Resources Director,Dr McMurray (NIMTDA), and would also like to invite you to attend to provide input in relation to dental practitioners employed by HSC organisations. The purpose of this group will be to further develop the framework prior to wider consultation, utilising the knowledge and experience of working group members who have implemented the processes in MHPS. Dates of meetings and the Terms of Reference will be circulated in due course.

I have also attached revised medical appraisal documentation for your information. This reflects the revised Good Medical Practice Framework and was developed by the CiC appraisal sub-group, signed off by the BMA and will be piloted in the Belfast HSC Trust from Nov-Jan 2012.

Regards

Jane

Jane Lindsay
Project Manager-Confidence in Care
DHSSPS,
C3.20,Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Personal Information redacted by the USI Mobile Personal Information redacted by the USI


CiC_Revision of MHPS_V4_CURR...


CiC_Revision of MHPS_V4_CURR...


CiC_ HSCNI Career Grade Me...


CiC_ HSCNI Career Grade Me...

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

APPRAISAL DOCUMENTS

SUPPORTING REVALIDATION FOR ALL CAREER GRADE MEDICAL STAFF

CONTENTS

Details of Appraiser(s)				
Year		**Name**	**GMC Number**	**Date**
1				
2				
3				
4				
5				

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

FORM 1 - BACKGROUND DETAILS

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 1 is to provide basic background information about you as an individual including brief details of your career and professional status.*
- *The form includes an optional section for any additional information.*

1.1 Full name	
1.2 GMC Registered address (contact address if different)	
1.3 Main employer	
1.4 Main place of work	
1.5 Other employers/ places of work	
1.6 Date of primary medical qualification	
1.7 GMC registration number and type	
1.8 Start date of first substantive appointment in HSC as a trained doctor	
1.8 GMC Registration date and specialties	
1.9 Title of current post and date appointed	
1.10 For any specialist registration / qualification outside UK, please give date and specialty	
1.11 Please list any other specialties or sub-specialties in which you are registered	
1.12 Is your registration currently in question?	
1.13 Date of last revalidation (if applicable)	
1.14 Please list all posts in which you have been employed in HSC and elsewhere in the last five years (including any honorary and/or part-time posts)	

ANY ADDITIONAL INFORMATION

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

FORM 2 - CURRENT MEDICAL ACTIVITIES

- *This form should be completed by the appraisee in advance of the appraisal.*
- *The aim of Form 2 is to provide an opportunity to describe your current post(s) in the HSC, in other public sector bodies, or in the private sector, including titles and grades of any posts currently held or held in the past year.*
- *Information should cover your practice at all locations since your last appraisal or during the last 12 months whichever is longer.*
- *You may wish to comment in addition on factors which affect the provision of good health care.*

2.1 Please give a short description of your work, including the different types of activity you undertake	
2.2 List your main sub-specialist skills and commitments / special interests	
2.3 Please give details of any emergency, on-call and out of hours responsibilities	
2.4 Please give details of out-patient work if applicable	
2.5 Details of any other clinical work	
2.6 In which non-HSC hospitals and clinics do you enjoy practising privileges or have admitting rights? Please give details including: ▪ Number and type of cases. ▪ Any audit or outcome data for the private practice. ▪ Details of any adverse events, critical incidents. ▪ Details of any investigations into the conduct of your clinical practice or working relationships with colleagues	

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

2.7 List any non-clinical work that you undertake which relates to teaching	
2.7.1 List any non-clinical work that you undertake which relates to management	
2.7.2 List any non-clinical work that you undertake which relates to research	
2.7.3 List any work you undertake for regional, national or international organisations.	
2.7.4 Please list any other activity that requires you to be a registered medical practitioner	

CURRENT JOB PLAN

If you have a current job plan, please attach it. If you do not have a current job plan, please summarise your current workload and commitments in the space below: -

ADDITIONAL INFORMATION

Please use to record issues which impact upon delivery of patient care.

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

FORM 3 - SUPPORTING INFORMATION and SUMMARY OF APPRAISAL DISCUSSION

This portfolio of evidence is structured around the GMC's 4 Domains and 12 Attributes within 'Good Medical Practice' (GMP). It is envisaged that this portfolio will be developed over a 5 year cycle. It is very unlikely that a practitioner will produce complete evidence against every aspect of each attribute every year. However there are certain elements which should be produced every year such as the Health and Probity statements.

The appraisee should consider which speciality specific evidence they need to include to satisfy their own College requirements.

DOMAIN 1 - Knowledge, Skills and Performance

Attribute: 1.1 Maintain your professional performance
Attribute: 1.2 Apply knowledge and experience to practice
Attribute: 1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible.

	List of Evidence	Applicable Date	1.1	1.2	1.3
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Discussion

Actions Agreed

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

DOMAIN 2 - Safety and Quality

Attribute: 2.1 Contribute to and comply with systems to protect patients
Attribute: 2.2 Respond to risks to safety
Attribute: 2.3 Protect patients and colleagues from any risk posed by your health

	List of Evidence	Applicable Date	2.1	2.2	2.3
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Discussion

Actions Agreed

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

DOMAIN 3 - Communication, Partnership and Teamwork

Attribute: 3.1 Communicate effectively
Attribute: 3.2 Work constructively with colleagues and delegate effectively
Attribute: 3.3 Establish and maintain partnerships with patients

	List of Evidence	Applicable Date	3.1	3.2	3.3
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Discussion

Actions Agreed

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

DOMAIN 4 - Maintaining Trust

Attribute:4.1 Show respect for patients
Attribute:4.2 Treat patients and colleagues fairly and without discrimination
Attribute:4.3 Act with honesty and integrity

	List of Evidence	Applicable Date	4.1	4.2	4.3
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Discussion

Actions Agreed

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

FORM 4 - PERSONAL DEVELOPMENT PLAN

In this section the appraiser and appraisee should review progress against last year's personal development plan and identify key development objectives for the year ahead, which relate to the appraisee's personal and/or professional development. This will include action identified in the summary above but may also include other development activity, for example, where this arises as part of discussions on objectives and job planning. Please indicate clearly the timescale within which these objectives should be met.

The important areas to cover: action to maintain skills and levels of service to patients; action to develop or acquire new skills; action to change or improve existing practice

Review of last year's Personal Development Plan		
Development needs	**Actions agreed**	**Has this been achieved (Yes, No, Partially)? If no or partially – why was it not fully achieved?**

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:	GMC Number:	Appraisal Period:

PERSONAL DEVELOPMENT PLAN for the year ahead		
Development needs	**Actions agreed**	**Target dates**

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:		Appraisal Period
GMC Number:		

FORM 5 - SIGN OFF

We confirm that this summary is an accurate record of the appraisal discussion, the key documents used, and of the agreed personal development plan:

APPRAISEE

Signature of Appraisee: : _____ Date: _____

APPRAISER

Signature of Appraiser: _____ Name of Appraiser: _____

GMC Number: _____ Date: _____

CO-APPRAISER (if applicable)

Signature of Co-Appraiser: _____ Name of Co-Appraiser: _____

GMC Number: _____ Organisation: _____

When you have completed the appraisal process, please do the following: -

	Action	Complete
1	Check that the appraiser and the appraisee have completed the Personal Development Plan Form 4.	
2	Check that the appraiser and the appraisee have signed the sign off (Form 5).	
3	Check that the appraisee has signed an annual statement on Health	
4	Check that the appraisee has signed an annual statement on Probity	
5	Return a copy of the required forms as identified in your organisation's appraisal policy.	

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:		Appraisal Period
GMC Number:		

Appendix 1

Summary of Appraisals

To be updated by appraiser annually

Details of Appraisals				
Year		**Appraiser**	**GMC Number**	**Date**
1				
2				
3				
4				
5				

Essential Components

Appraisers to note completion of specific items required for revalidation (e.g. completion of Multi-source feedback)

General for all doctors	Reviewed by	Date

Specific for area of clinical practice	Reviewed by	Date

HSCNI CAREER GRADE MEDICAL STAFF APPRAISAL DOCUMENTATION

Name:		Appraisal Period
GMC Number:		

Appendix 2

Circumstances mitigating against achieving full requirements.

Circumstance	Appraiser	Date

COMMENTS ON DRAFT NEW VERSION OF "MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY.

General Comments:

- Welcome the fact that the previous document is being reviewed and updated.

- Need to ensure that document is "user friendly": ie it needs to flow from one section to another and not jump back and forward between sections. As an example, para 48 sets out the process for setting up an extended investigation but the process for making that decision does not come until para 72.

- There needs to be specific clarification re the roles and responsibilities around Doctors in Training. In particular, in relation to paras 21 and 23-25 there needs to be full transfer of information between NIMDTA and Trusts in relation to any Doctors in Training who are the subject of any procedures under this guidance.

- The terminology in this document needs to be consistent throughout – formal/informal and preliminary (Stage1)/extended (stage 2) investigations seem to be used interchangeably in different sections of this document.

- The document refers very explicitly to NCAS: given the current discussions around the future of NCAS it may be advisable to avoid reference to a particular organisation.

- In the previous document there was a clear distinction between the Informal process and the Formal process in relation to the action taken in response to an investigation. This seems to have been lost from this document. In this regard it would be better to separate out the Investigation stages (stage 1 and stage 2) from the Action stages (informal and formal). For example, para 152 refers to issues being dealt with Informally, but the process for doing this is not mentioned at an earlier stage of the document.

SPECIFIC POINTS.

- Para 28: concerns will be wider than just patient safety:

- Para 36: the distinction between Stage 1 and stage 2 investigation should be more clearly set out. In addition, the document is confusing as to who the investigator should be: para 39 says the investigator should have no connection with the subject whilst para 46 says the investigator should be a senior clinician – in practice this is likely to be someone who has worked with the subject.

- Para 53(a): bringing "all concerns" to the attention of the CEO is not practical and is not consistent with other parts of this document (para 44):

- p24: role of Case Manager: "will lead the extended investigation": this sounds like the role of the Case Investigator. Suggest that the Case Manager should "oversee the extended investigation".

- The roles and responsibilities of the Medical Director and the Director of HR need to be set out:

- p26: the wording of the last bullet point (re intractable problems) is not clear and should be reworded.

- Para 56 refers to the Formal process being on p 42 whereas it is on p78.

- Para 71: wording of second last bullet point needs to be reviewed:

- Para 78: further thought needs to be given as to when NCAS (or equivalent) should be involved. I suggest that NCAS be involved at the end of the preliminary investigation if concerns have been found rather than when concerns have first emerged and temporary exclusion has been put in place by the Trust pending the preliminary investigation.

- Para 150: this refers to "local processes" in paras 15-17, but paras 15-17 do not mention "local processes" – this needs to be reviewed.

P Flanagan, Northern HSC Trust 26th Sept 2011

Roberts, Naomi

From: Watson, Peter [redacted]
Sent: 27 September 2011 15:16
To: Lindsay, Jane
Cc: Stevens, Tony
Subject: Revisions to MHPS

Follow Up Flag: Follow up
Flag Status: Completed

Jane,

Tony has asked that I speak with you regarding training in both the procedure of MHPS and in formal investigations. We would be keen that such training be considered at this time and in the context of the proposals to revise the procedures.

I would be grateful if you could call me to discuss at your convenience.

Thanks

Peter

Tel [redacted] or [redacted]

_____

Roberts, Naomi

From: Woods, Paddy
Sent: 28 September 2011 09:00
To: Lindsay, Jane
Cc: Hutchison, Ruth
Subject: FW: TRIM DHSSPS Document : DH1/11/172946 : Letter Dr Woods to Anne Kilgallen-MHPS Working Group-Sep11.pdf

For info

-----Original Message-----
From: Quinn, Sonya
Sent: 22 September 2011 09:20
To: Woods, Paddy
Subject: FW: TRIM DHSSPS Document : DH1/11/172946 : Letter Dr Woods to Anne Kilgallen-MHPS Working Group-Sep11.pdf

-----Original Message-----
From: Kilgallen, Anne [mailto:[redacted]]
Sent: 21 September 2011 19:26
To: Quinn, Sonya
Cc: Simpson, John; peter.flanagan[redacted]; tony.stevens[redacted]; charlie.martyn[redacted]
Subject: RE: TRIM DHSSPS Document : DH1/11/172946 : Letter Dr Woods to Anne Kilgallen-MHPS Working Group-Sep11.pdf

This e-mail is covered by the disclaimer found at the end of the message.

Dear Paddy

We discussed your letter (about the framework document and its revision) when we gathered on Monday. I have agreed to join the short term group you plan to establish with Charlie as seconder should I be unavailable to attend. Each Medical Director plans to provide individual feed back to you on the draft document as soon as possible.

We also discussed support for appraisal / revalidation. We know Tony has forwarded a paper outlining his needs. I agreed to summarise on behalf of the four Trusts you haven't heard from and I hope to have that with you within the next 10 days (allowing for some consultation between us).

We hope this meets your needs at the moment. Please let me know if you need anything further.

Kind regards

Anne

-----Original Message-----
From: Quinn, Sonya [mailto:[redacted]]
Sent: 12 September 2011 11:07
To: Kilgallen, Anne
Cc: Simpson, John; peter.flanagan[redacted]; tony.stevens[redacted]; charlie.martyn[redacted]

Subject: TRIM DHSSPS Document : DH1/11/172946 : Letter Dr Woods to Anne Kilgallen-MHPS Working Group-Sep11.pdf

Please find attached letter from Dr Paddy Woods.

------< TRIM Record Information >------

Record Number : DH1/11/172946
Title : Letter Dr Woods to Anne Kilgallen-MHPS Working Group-Sep11.pdf

Roberts, Naomi

From: Lindsay, Jane
Sent: 15 November 2011 10:43
To: Kilgallen, Anne; Roberts, Margot; Mervyn Barkley; O'Carolan, Donncha; Reid, Simon; kieran.donaghy[Personal Information redacted by the USI]
Cc: Beck, Lorraine; Dardis, Pauline; Davey, Noreen; andrea.[Personal Information redacted by the USI]; Hutchison, Ruth
Subject: Revision of MHPS
Attachments: Revision of MHPS (v4) with changes made 131111.DOC; CiC_Glossary_MHPS.DOC

Importance: High
Sensitivity: Confidential

Follow Up Flag: Follow up
Flag Status: Flagged

Colleagues,

Re: Revision of Maintaining High Professional Standards Working Group, Friday 18th November,11:00,C5.17(Dr Woods' Office), Castle Buildings.

I have attached the current revision of MHPS for your consideration ahead of our meeting on Friday. You will note that this is very much a working draft and we look forward to hearing your feedback and suggestions. Also attached is a Glossary that will be developed as the revision progresses.

Our key aims in developing the framework are:

* Incorporate the learning from those who have used the processes and guidance in HSC organisations
* Develop the guidance element of the framework to ensure it is fit for purpose, clear to follow and compliments existing organisational policies
* Highlight the need to ensure robust recording when addressing concerns including decision made and how they were reached
* Stress the importance of reviewing investigations at key intervals
* Ensuring that measures required to protect patients and the public are considered at the commencement and throughout an investigation, and reviewed to ensure they still address identified risks.

We have been considering a the range of resources provided by the Labour Relations Agency in work undertaken to date that provide succinct guidance in relation to Conducting Employment Investigations, Handling Discipline and Grievances at Work and Advice on Managing Poor Performance. These documents are available on the LRA website should you wish to review prior to our meeting (link below) http://www.lra.org.uk/index/agency_publications-2/advice_and_guidance_on_employment_matters-3/advisory_guides2.htm.

I have received apologies for this meeting from Donnacha O'Carolon and Kieran Donaghay,both very welcome to provide comments to me by email and I will ensure these are considered at Friday's meeting.

Kind Regards

Jane

Jane Lindsay
Project Manager-Confidence in Care
DHSSPS,
C3.20,Castle Buildings

Stormont Estate
Belfast BT4 3SQ
Personal Information redacted by the USI Mobile Personal Information redacted by the USI

Maintaining High Professional Standards In the 21st Century

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

Department of Health, Social Services & Public Safety
November 2011

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21st CENTURY

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

TABLE OF CONTENTS:

INTRODUCTION

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

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

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

4. This framework is in 5 sections and covers:

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

Commented [JL1]: UPDATE

Background

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

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

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

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

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

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

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

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

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

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

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

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

~~Concerns about~~

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

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

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

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

SECTION 1- STRATEGIC AND REGIONAL CONTEXT OF THIS FRAMEWORK

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

HSCNI GOVERNANCE AND ACCOUNTABILITY

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

~~HSCNI GOVERNANCE AND ACCOUNTABILITY~~

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

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

PROFESSIONAL REGULATION OF DOCTORS AND DENTISTS

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

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

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

REVALIDATION

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

MEDICAL REVALIDATION AND THE RESPONSIBLE OFFICER

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

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

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

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

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

a. To ensure that regular appraisals are undertaken

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

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

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

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

REVALIDATION FOR DENTISTS

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

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

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

REVALIDATION AND MANANGING CONCERNS

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

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

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

SECTION 2 IDENTIFYING CONCERNS

HOW CONCERNS ARE IDENTIFIED

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

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

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

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

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

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

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

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

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

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

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

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

Commented [JL3]: Clarify this paragraph is consistent with policy

SUMMARY OF KEY ACTIONS NEEDED WHEN A CONCERN ARISES

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

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

PROTECTING PATIENTS AND THE PUBLIC

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

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

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

SECTION 3: INVESTIGATION

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

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

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

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

UNDERTAKING AN INVESTIGATION

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

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

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

~~40~~42 The following principles from the Labour Relations Agency [10] provide a useful principles when planning and undertaking an investigation:

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

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

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

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

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

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

➢ ***When and Where?***

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

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

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

COLLECTING EVIDENCE

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

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

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

Commented [PW4]: What tribunal?

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

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

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

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

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

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

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

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

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

STAGE 1-PRELIMINARY INVESTIGATION

4446 The investigatory process should commence with a preliminary investigation to establish the factsidentify the issues surrounding the concern that has been identified. This first stage should take account of the evidence to hand, alongside any comments the practitioner wishes to make, and should provide an indication of the substance of the concern and the most appropriate course of action.

4547 The Clinical Director, Human Resources Director, and Medical Director/Responsible Officer should be informed of the investigation. They may decide to inform the Chief Executive and/or Executive Board at this stage if there is an apparent risk to patient safety, and/or for reputational damage to the organisation:

Commented [JL5]: Check organisational processes

4648 The preliminary investigation should be appropriately documented, resourced and recorded from the outset. If further investigation is required, the methodology and findings from the preliminary investigation will be critical in establishing the terms of reference of an extended investigation. Frequent and factual Robust recording will also provide assurance to the organisationorganisation, and the practitioner that, that the appropriate process has been followed and how decisions were reached.

4749 The preliminary investigation should be undertaken by a senior clinician in the HSC organisation and should include:

- Review of relevant clinical or administrative records

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

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

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

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

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

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

STAGE 2: EXTENDED INVESTIGATION

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

Commented [JL8]: ? THRESHOLD CRITERIA NEEDED

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

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

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

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~~TRAINING~~

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

PROCESS FOR AN EXTENDED INVESTIGATION

OVERSIGHT

~~DEFINITION OF ROLES~~

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

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

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

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

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

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

Commented [JL10]: Define accompanied in this instance

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

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

INVESTIGATION

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

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

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

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

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

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

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

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

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

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

TIMESCALES AND DECISION MAKING

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

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

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

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

- there are concerns about the practitioner's health that should be considered by the HSC body's occupational health service, and the findings reported to the employer;

- there are concerns about the practitioner's clinical performance which require further formal consideration by the NCAS ;

- there are serious concerns that fall into the criteria for referral to the GMC or GDC; there are intractable problems and the matter should be put before a clinical performance panel.

Formal processes are illustrated in the diagram on page 42.

PROCESS FOR SMALLER ORGANISATIONS

~~67~~73 Many smaller organisations may not have all the necessary personnel in place to follow the procedures outlined in this document. For example, some smaller organisations may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

~~68~~74 Such organisations should consider working in collaboration with other local HSC organisations (e.g. other Trusts) in order to provide sufficient personnel to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HSC organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

TERMINATION OF EMPLOYMENT WITH PROCEDURES INCOMPLETE

Commented [JL11]: Does this refer to resignation?

~~69~~75 Where the employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

~~70~~76 There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate

with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

~~74~~77 Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The employer must make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the employer must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children and Vulnerable Adults List (held by the Department of Employment and Learning). CONFIRM THIS IS STILL CORRECT TITLE ?ISA

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

~~72~~78 In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

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

CONFIDENTIALITY

~~73~~79 Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

~~74~~80 Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

~~**TRANSITIONAL ARRANGEMENTS**~~

~~**69.** On implementation of this framework, the new procedures must be followed, as far as is practical, for all existing cases taking into account the stage the case has reached.~~

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SECTION 4 OPTIONS FOLLOWING INVESTIGATION

~~75~~81 This section outlines the key principles in relation to decision making following an investigation and the range of measures that may be taken to manage the concern while ensuring patient safety.

THE DECISION MAKING PROCESS

~~76~~82 Once the investigation has established the facts, an entirely separate process is needed to decide what action (if any) is needed. Key principles in relation to decision making can be summarised as follows:

- Patient and public safety must be the foremost consideration
- A decision must be made, recorded and all relevant parties informed
- There should be complete separation between the investigation and decision making process
- The decision making process must be seen to be fair, impartial, consistent and timely
- Expert input should be sought where necessary
- A range of options should be considered based on the circumstances of the individual doctor or dentist
- Organisations should consider opportunities for internal learning ~~their own learning~~ and make appropriate changes
- Individuals should be seek out support

Commented [JL12]: Which individuals?

- The doctor or dentists should have the right to appeal against any decisions made, except for decisions to refer cases to the regulator, to the police or to the counter fraud unit.

OPTIONS FOLLOWING PRELIMINARY INVESTIGATION

~~77~~83 At the conclusion of the preliminary investigation, the information collated should be reviewed and a decision made in relation to what, if any, next steps should be taken. As a first step, this preliminary investigation is essential to verify or refute the substance and accuracy of any concerns or complaints. This can be ~~is a~~a difficult decision and should not be taken alone but in consultation with the Responsible Officer, Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

~~78~~84 At this stage of the investigatory process a range of options are available to organisations. These options are not mutually exclusive - patient protection and action required to manage the concern may require implementation of one or more of the following :

- No action to be taken
- Remedial action required
- Measures to ensure patient safety required – restriction on practice or exclusion
- Local process agreed with the practitioner to be implemented
- Proceed to Stage 2- Extended Investigation

Commented [JL13]: Define local processes

NO ACTION REQUIRED

85 If, at the conclusion of the preliminary investigation, there has been no evidence to support the concern and no identified risk to patient and public safety identified then no further action is required. ~~it has been agreed that no action is required,~~T ~~t~~he practitioner should be informed of this decision as soon as possible and t~~. T~~he record of the investigation ~~should be~~

~~c~~completed. This should ~~and~~ include the rationale for the decision and those involved in the decision made. ~~.~~ This record should be held on the practitioner's personnel file for future record.

~~CHECK POLICY~~

Commented [JL14]: Need HR Input

REMEDIAL ACTION REQUIRED

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~~79~~86 If the outcome of the preliminary investigation is the identification of a performance concern (as per definition in paragraph 2 of this Framework- referring to all aspects of a practitioner's work including conduct, health and clinical performance), consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. Paragraphs 207-215 of this paper outline the service provided by NCAS.

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MEASURES TO ENSURE PATIENT SAFETY

RESTRICTIONS ON PRACTICE

~~80~~87 When significant issues relating to performance are identified at any stage of the processes described in this framework which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties and obtain relevant undertakings e.g. regarding practice outside the organisation in another HSC organisation or private practice. Any restrictions on practice must be an interim measure and should be documented and kept under review during the investigatory process. If the concern raised and upheld following a preliminary investigation is of sufficient concern to warrant restrictions on practice or immediate exclusion, an extended investigation should be commenced.

IMMEDIATE EXCLUSION

8188 An immediate time limited exclusion from the workplace may be necessary to protect the interests of patients or other staff; or where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

8289 The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director/Responsible Officer and appropriate representation from Human Resources.

Commented [RH15]: ? is this a preliminary investigation

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8390 The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CE, Medical Director/Responsible Officer and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Responsible Officer /Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

8491 The clinical manager, having obtained the authority to exclude, must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting.

8592 Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should

be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

~~86~~93 All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

~~87~~94 The 4 week exclusion period should allow sufficient time for initial or further investigation to determine a clear course of action, including the need for formal exclusion, remediation, disciplinary action and/or referral to the regulator.

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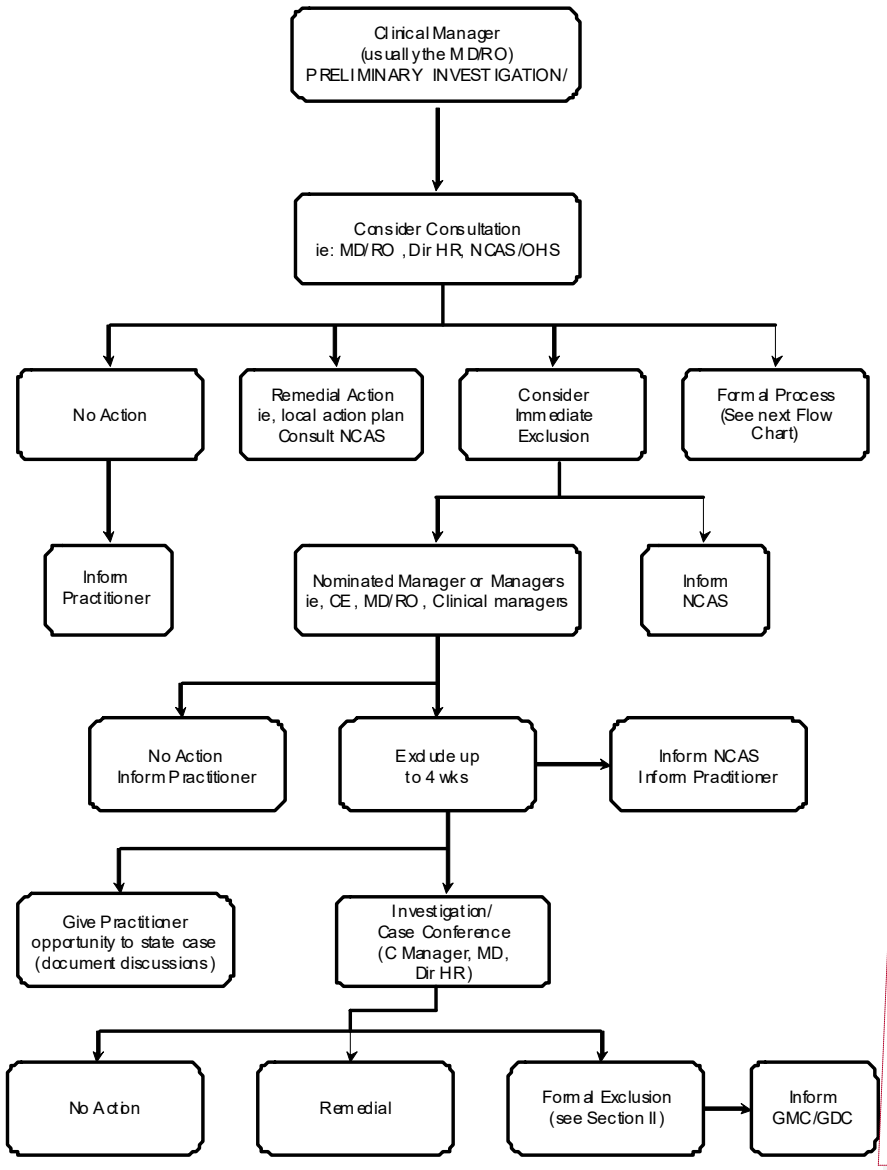
~~88~~95 At any point in the process where the Medical Director/Responsible Officer has reached a decision that a practitioner is to be the subject of exclusion, the regulatory body should be notified. Users of this Framework should refer to the DHSSPS Guidance Issuing Alert Letters (circular HSS (TC8) (6)/98) and Guidance on Information Sharing to Provide Assurance.

~~89~~96 Paragraphs 109-130 of this framework set out the procedures to be followed should an extended investigation indicate that a longer period of formal exclusion is required.

~~90~~97 The following diagram provides an overview of the informal process.

INFORMAL PROCESS



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OPTIONS FOLLOWING EXTENDED INVESTIGATION.

~~91~~98 Options following an extended investigation are described in this section. As with~~per~~ options following a preliminary investigation, these are not mutually exclusive and ensuring patient and public safety, and action required to manage the concern may require implementation of one or more of the following :

- No further action
- Referral to OHS
- Measures to protect patients - restriction of practice & exclusion from work
- Conduct panel
- Clinical Performance Panel
- Referral to GMC/GDC
- Referral to the NCAS.

NO FURTHER ACTION

~~92~~99 If, at the conclusion of an extended investigation, it has been agreed that no further action is required, the practitioner should be informed of this decision as soon as possible. The investigatory record should be completed and include the rationale for this decision. This record should be held on the practitioner's personnel file for future record.

REFERAL TO OCCUPATIONAL HEATH SERVICE

~~93~~100 When the findings of an extended investigation demonstrate there are concerns about the practitioner's health that should be considered by the HSC body's Occupational Health Service (OHS) and the findings reported to the employer.

~~94~~101 In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. Employers should be aware that the practitioner may also self refer to OHS.

~~95~~102 The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the HSC.

HANDLING HEALTH ISSUES

~~96~~103 On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director/Responsible Officer. ~~A and a~~ meeting should be convened with the Director of HR, the Medical Director/Responsible Officer or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)[12]. The practitioner may be accompanied to these meetings (as defined in paragraph 49). Confidentiality must be maintained by all parties at all times.

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~~97~~104 The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.

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

~~98~~105 In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures or misconduct procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

~~99~~106 A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

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RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

~~100~~107 Wherever possible the organisation should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of action that may be taken in these circumstances, in consultation with OHS and having taken advice from NCAS and/or NIMDTA if appropriate.

~~101~~108 Examples of action to take:

- sickness absence for the practitioner (the practitioner should be ~~to be~~ contacted frequently to ensure they receive any support they may require ~~on a pastoral basis to stop them feeling isolated)~~);
- remove the practitioner from certain duties;
- make adjustments to the practitioner's working environment;
- reassign them to a different area of work;
- arrange re-training for the practitioner;

- consider whether the Disability Discrimination Act (DDA) applies (see below), and, if so, what other reasonable adjustments might be made to their working environment.
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DISABILITY DISCRIMINATION ACT (DDA)

~~102~~109 Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.

~~103~~110 Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non - disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

~~104~~111 Examples of reasonable adjustment

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

- establish mentoring arrangements.

~~105~~112 In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and HSC Superannuation Branch.

~~106~~113 Note. Special Professional Panels (generally referred to as the "three wise men") were set up under circular TC8 1/84. This part of the framework replaces those arrangements and any existing panels should be disbanded.

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MEASURES TO PROTECT PATIENTS:
RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK

~~107~~114 This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions). Under the Directions on Disciplinary Procedures 2005, HPSS employers must incorporate these principles and procedures within their local procedures. The guiding principles of Article 6 of the Human Rights Act must be strictly adhered to.

~~108~~115 In this part of the framework, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

~~109~~116 The Directions require that HSC bodies must ensure that:

- exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;

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

MANAGING THE RISK TO PATIENTS

~~110~~117 Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.

~~111~~118 The purpose of exclusion is:

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

~~112~~119 It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

THE EXCLUSION PROCESS

~~113~~120 **Under the Directions, an HSC body cannot require the exclusion of a practitioner for more than four weeks at a time.** The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under

the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key principles ~~aspects~~ of exclusion from work

~~114~~121 Key aspects include:

- an initial "immediate" exclusion of no more than four weeks if warranted as set out in paragraphs 77-84
- notification of the NCAS before immediate and formal exclusion;
- formal exclusion (if necessary) for periods up to four weeks;
- ongoing advice on the case management plan from the NCAS;
- appointment of a designated Board member to monitor the exclusion and subsequent action;
- referral to NCAS for formal assessment, if part of case management plan;
- active review by clinical and case managers to decide renewal or cessation of exclusion;
- a right to return to work if review not carried out;
- performance reporting on the management of the case;
- programme for return to work if not referred to disciplinary procedures or clinical performance assessment;
- a right for the doctor to make representation to the designated Board member

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~~115~~122 The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CE, Medical Director/Responsible Officer and the

Clinical Directors for staff below the grade of consultant. For consultants it should include the CE and Medical Director/Responsible Officer.

Exclusion other than immediate exclusion

~~116~~123 A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), whether there is reasonable and proper cause to exclude. The NCAS must be consulted where formal exclusion is being considered. If a Case Investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.

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~~117~~124 The report should provide sufficient information for a decision to be made as to whether:

(i) the allegation appears unfounded; or
(ii) there is a misconduct issue; or
(iii) there is a concern about the practitioner's clinical performance; or
(iv) the complexity of the case warrants further detailed investigation before advice can be given.

~~118~~125 Formal exclusion of one or more clinicians must only be used where:

a. there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of allegations of misconduct; concerns around the functioning of a clinical team which are likely to adversely affect patients; or concerns about poor clinical performance;

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

~~119~~126 Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

~~120~~127 When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion (paragraph 49 defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

~~121~~128 The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 121, and the need to remain available for work paragraph 122) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

~~122~~129 In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable periods until the completion of disciplinary procedures, if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time

and be subject to review (see paras 26 – 31 relating to the review process). The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

~~123~~130 If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.

~~124~~131 If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

Exclusion from premises

~~125~~132 Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff

Keeping in contact and availability for work

~~126~~133 Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the HSC employer. This caveat does not refer to time for which they are not being paid by the HSC employer. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

~~127~~134 The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in CPD and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

Informing other organisations

~~128~~135 Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HSC and non-HSC) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HSC employer has

placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer[13] Ref Information Sharing Guidance

~~129~~136 Where the Case Manager has good grounds to believe that the practitioner is practicing in other parts of the HSC, or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the CMO of the Department to consider the issue of an alert letter.

~~130~~137 No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been commonly used in the recent past. No HSC organisation may use "gardening leave" as a means of resolving a problem covered by this framework.

Existing suspensions & transitional arrangements

~~131~~138 On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

~~132~~139 The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

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

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

Regular review

~~133~~140 The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[14]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

~~134~~141 The HSC body must take review action before the end of each 4-week period. The table below outlines the various activities that must be undertaken at different stages of exclusion.

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

EXCLUSION REVIEWS

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. Case Manager submits advisory report of outcome to CE and Medical Director. Each review is a formal matter and must be documented as such. The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: A report must be made by the Medical Director to the CE: outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed

	a timetable for completion of the investigation. The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. The case must be formally referred back to the NCAS explaining: why continued exclusion is thought to be appropriate; what steps are being taken to complete the investigation at the earliest opportunity. The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, A further position report must be made by the CE to the Department indicating: the reason for continuing the exclusion; anticipated time scale for completing the process; actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

~~135~~142 Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

The role of the Department in monitoring exclusions

~~136~~143 When the Department is notified of an exclusion, it should confirm with the NCAS that they have been notified.

~~137~~144 When an exclusion decision has been extended twice (third review), the CE of the employing organisation (or a nominated officer) must inform the Department of what action is proposed to resolve the situation.

RETURN TO WORK

~~138~~145 If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

CONDUCT HEARINGS AND DISCIPLINARY PROCESSES

~~139~~146 When the outcome of an extended investigation shows that there is a case of misconduct, this must be put to a conduct panel. Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question.

~~140~~147 It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (paragraphs 149-204 refer).

~~141~~148 Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation[15].

~~142~~149 Employers are strongly advised to seek advice from NCAS in misconduct cases, particularly in cases of professional misconduct.

~~143~~150 HSC bodies must work in partnership with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts.

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

CODES OF CONDUCT

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

(i) a refusal to comply with the requirements of the employer where these are shown to be reasonable;
(ii) an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of doctors and dentists by their regulatory body[16];
(iii) the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
(iv) wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

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

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

of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.

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

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

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

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

145 Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.? Check accuracy of reference

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

146 There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made.

147 Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should, as a matter of good practice, explain the reasons for taking such action.

Dropping of charges or no court conviction

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

CLINICAL PERFORMANCE PANEL

INTRODUCTION & GENERAL PRINCIPLES

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

150 Concerns about the clinical performance of a doctor or dentist may arise as outlined in paragraphs 26-27. Advice from the NCAS will help the employer to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through agreed local processes set out in Section I (paragraphs 15 – 17) the matter must be referred to the NCAS before consideration by a performance panel (unless the practitioner refuses to have his or her case referred).

151 Matters which may fall under the performance procedures include:
outdated clinical practice;

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

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

153 Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in paragraphs 57-60.

How to proceed where conduct and clinical performance issues are involved

154 It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

155 The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[17].

156 As set out in paragraphs 207-215, the NCAS can assist the employer to develop an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the

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

employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

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

HEARING PROCEDURE

The pre-hearing process

158 The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;

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

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;

- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;

- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.

- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

159 The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately

experienced medical or dental practitioner who is not employed by the Trust.[18] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

160 Arrangements must be made for the panel to be advised by:

- a senior member of staff from Human Resources;
- an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HSC employer;
- a representative of a university if provided for in any protocol agreed between the employer and the university.

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

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

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

Representation at clinical performance hearings

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

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

Conduct of the clinical performance hearing

165 The hearing should be conducted as follows:

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

- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

166 The order of presentation shall be:

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

Decisions

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

Possible decisions made by the clinical performance panel:

a. a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;

b. a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

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

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

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

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

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

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

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

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

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

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

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

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

176 It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re-hear the entire case but may direct that the case is re-heard if it considers it appropriate (see paragraph 177 below).

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

The appeal process

178 The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the clinical performance hearing, or order that the case is

re-heard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new clinical performance hearing.

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

The appeal panel

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

- an independent member (trained in legal aspects of appeals) from an approved pool.[19] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[20] who must also have the appropriate training for hearing an appeal.

[19] See Annex A.
[20] Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the local negotiating committee.

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

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

- a consultant from the same specialty or subspecialty as the appellant, but from another HSC/NHS employer[21];
- a senior Human Resources specialist.

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

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

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

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

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

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

Powers of the appeal panel

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

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

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

Conduct of appeal hearing

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

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

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

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

Decision

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

Action following hearing

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

APPEAL PANELS IN CLINICAL PERFORMANCE CASES update section

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

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

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

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

Creating and administering the list

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

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

201 The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the Judicial Studies Board. The framework, which can be adapted to suit particular circumstances sets out six headline competencies

featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

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

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

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

REFERRAL TO PROFESSIONAL REGULATOR

205 During the processes described in this framework, reference is made at key stages at which referral to the practitioner's professional regulator should be considered. These include:

- When a finding of misconduct has been upheld
- When a finding of unsatisfactory clinical performance has been reached.

206 Threshold criteria for referral under fitness to practice proceedings are referenced in paragraph 17 of this framework.

REFERRAL TO THE NCAS

207 The NCAS is a division of the NHS Patient Safety Agency and was established to assist healthcare managers and practitioners to understand, manage and prevent performance concerns.

208 At any stage in the handling of a case consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSC Trusts and practitioners. This includes:

- immediate telephone advice, available 24 hours;
- advice, then detailed supported local case management;
- advice, then detailed NCAS performance assessment;
- support with implementation of recommendations arising from assessment.

209 Employers or practitioners are at liberty to make use of the services of the NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in paragraphs 77-84 and 109-130 of this framework.

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

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

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

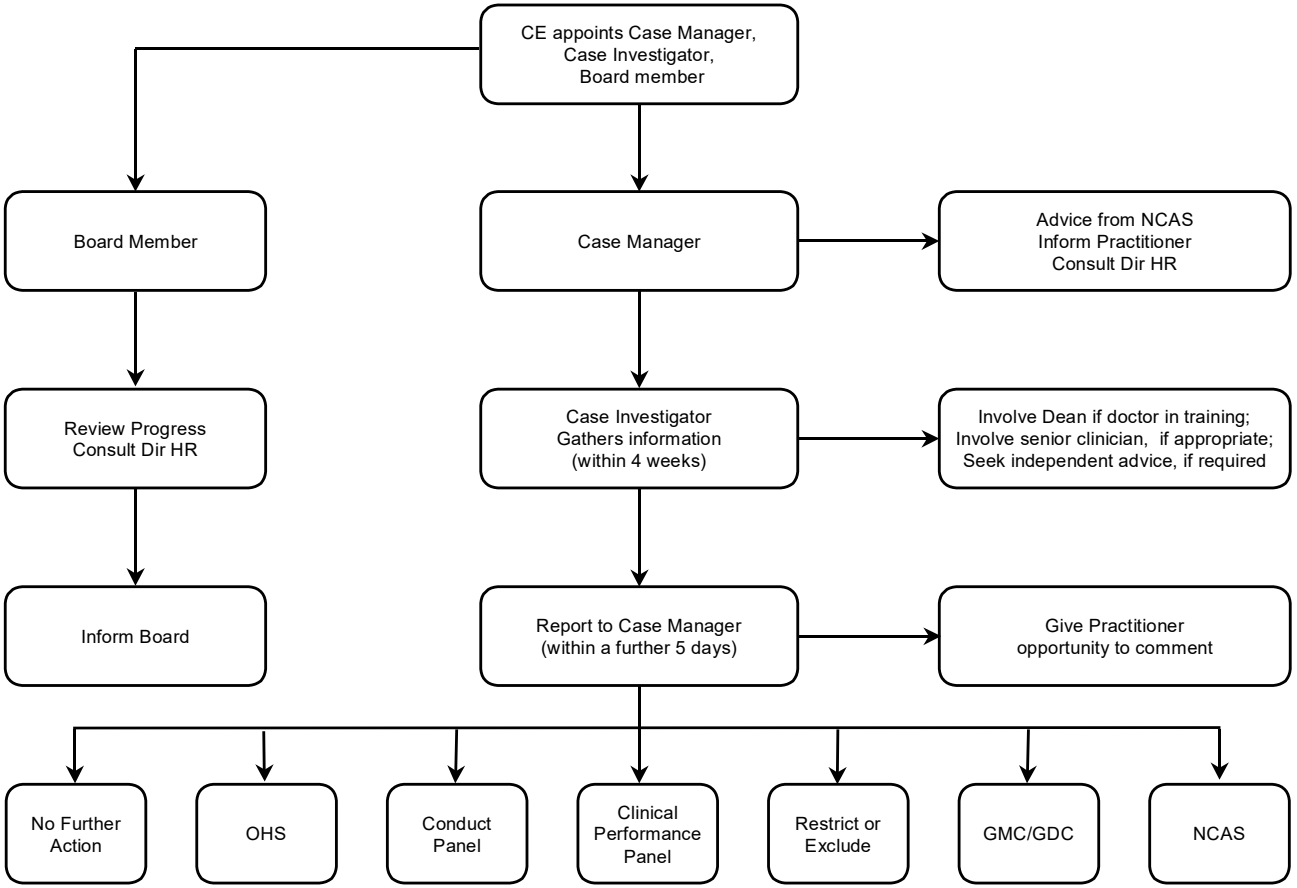
212 A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HSC or private sector other than their main place of HSC employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals in its Handbook. 22. See also circular HSS (TC8) 5/04.

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

214 The local action plan should be agreed by both the practitioner and a senior clinician in the organisation. A timescale should be defined for review and completion of the objectives of the action plan and progress documented.

215 Successful completion of the action plan should be documented and this information retained in the practitioner's personnel file

FORMAL PROCESS



HANDLING OF ILLNESS ARISING DURING EXTENDED INVESTIGATION

151 If an excluded employee or an employee facing any process in Stage 2 of this framework becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside these processes and the employer should take reasonable steps to give the employee time to recover and attend any hearing.

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152 Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

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

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Appendix 1 – Glossary

GLOSSARY - MHPS

Adverse incident[1]	Any event or circumstances that could have or did lead to harm loss or damage to people, property, environment or reputation.
Appraisal	A positive process of constructive dialogue, in which the doctor being appraised has a formal, structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It should support doctors in their aim to deliver high quality care whilst ensuring they are practicing within a safe and effective framework.
Case Review	An external, professional investigation of service provision by the relevant royal college/faculty at the requiest of an employer/contracting body….???NCAS
Concern[2]	Any aspects of a practitioner's practice, performance, conduct or behaviour which pose a threat to patient safety or public protection; expose services to financial or other substantial risk; undermine reputation or efficiency of services in some significant way; or are outside acceptable professional or working practice guidelines and standards.
Exclusion[3]	A temporary expedient which is a precautionary measure and not a disciplinary sanction. The purpose is to protect the interests of patients or other staff or to assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.
Extended investigation	A continuation of a preliminary investigation with wider scope to assess in more detail and clarify circumstances.
Clinical governance[4]	A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Intervention	An influencing force or act that occurs in order to modify a given state of affairs. / Interference so as to modify a process or situation[5]. check ref
Investigation	An inquiry carried out by a healthcare organisation into whether or not there is a problem to address in a practitioner's performance.[6]
'Look Back' exercise[7]	A re-examination of a process(es) or individual(s) which has delivered results that were not to the expected quality standard.
Mentorship[8]	Mentoring is guidance and support offered by a more experienced colleague. London Deanery

Commented [RH1]: Practitioner?

[1] HSCB 'Procedure for the reporting and follow up of Serious Adverse Incidents'
[2] NCAS 'The Back on Track Framwork for Further Training'
[3] Maintaining High Professional Standards in the Modern NHS – Feb 2005
[4] National Patient Safety Agency – 'Being Open'
[5] http://medical-dictionary.thefreedictionary.com/intervention
[6] How to Conduct a Local Performance Investigation – NHS Patient Safety Agency, NCAS January 2010
[7] Regional Governance Network NI Sub-Group Feb 07 – 'A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises'
[8] http://www.faculty.londondeanery.ac.uk/e-learning/supervision/clinical-and-educational-supervision

Patient safety[9]	The process by which an organisation makes patient care safer, This should involve risk assessment, the identification and management of patient-related risks, the reporting and analysis of incidents, and the capacity to learn from and follow-up on incidents and implement solutions to minimize the risk of them recurring
Preliminary investigation	An inquiry or information gathering proceeding to determine whether there is sufficient ground to engender a more extensive exercise.
Remediation[10]	The process of addressing concerns about practice (knowledge, skills and behaviours) that have been recognised, through assessment, investigation, review or appraisal, so that the practitioner has the opportunity to return to safe practice.
Restriction[11]	Restricting the practitioner to certain forms of clinical duties or restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling.
Root Cause Analysis (RCA)[12]	A systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individual concerned and seeks to understand the underlying causes and environmental context in which an incident happened.
Standard[13]	Sets out agreed specifications and/or procedures designed to ensure that a material, product, method of service is fit for purpose and consistently performs in the way it is intended.
Clinical supervision	A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations. DH 1993

[9] National Patient Safety Agency – 'Being Open'
[10] NCAS 'The Back on Track Framwork for Further Training'
[11] Maintaining High Professional Standards in the Modern NHS – Feb 2005
[12] National Patient Safety Agency – 'Being Open'
[13] National Patient Safety Agency – 'Being Open'

Clinical Review[14]	A re-examination of a medical or clinical process(es) or individual(s) which has delivered results that were not to the expected quality standard

[14] Regional Governance Network NI Sub-Group Feb 07 – 'A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises'

Chief Executive (CE) – all concerns must be registered with the CE who, should an extended investigation be required, must ensure that the following individuals are appointed;

b. the "designated Board member" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion or any representations about the investigation;

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

d. Case Investigator – this is the individual who will carry out the extended investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical

Director/Responsible Officer and Director of HR and should, where possible, be medically qualified;

e. the Director of HR's role will be to support the Chief Executive and the Medical Director/Responsible Officer.

Roberts, Naomi

From: Lindsay, Jane
Sent: 17 November 2011 14:35
To: Colville, Victoria
Subject: RE: Maintaining High Professional Standards

Hi Victoria

Nothing much to add other than the framework revision is ongoing and will be consulted upon in due course.

Best Wishes

Jane

From: Colville, Victoria
Sent: 17 November 2011 13:54
To: Lindsay, Jane
Subject: Maintaining High Professional Standards

Hi Jane

I think it's been a while since I pestered you! We have a BMA Joint Forum meeting coming up on 6 December and I was wondering can you give me an up-date for the Chairs brief re Maintaining High Professional Standards. Im not sure yet if Paddy Woods will be in attendance to provide an up-date.

Thanks a lot

Victoria

Victoria Colville
DHSSPS Pay & Employment Unit
Room D1
Castle Buildings
Personal Information redacted by the USI

Meeting of MHPS Working Group
Friday 18th November 2011

In Attendance:

Dr Woods
Dr Kilgallen
Margot Roberts
Mervyn Barkley
Jane Lindsay

Summary of discussion:

1. Current revision of framework is too long and should focus on the formal and informal processes, investigations and roles and responsibilities.

2. There is a degree of ambiguity in relation to roles and responsibilities when commencing an investigation and subsequent action if required. The role of the Medical Director/Case Manager needs clarification; when should they be intimately *involved* in cases and when they should be made *aware*? Their role in relation to decision making is crucial, as is the obligation placed on them to accept and act on the findings of an investigation.

3. Separate section on managing concerns in relation to trainees may be helpful given potential for lack of clarity in relation to role of Employer and that of the Deanery & Responsible Officer. Issues arising where Deanery may have difficulty in securing a placement for a Trainee when there are concerns about his/her performance.

4. There is a need to highlight the importance of organisational policies for performance management of all employees e.g. disciplinary, capability, health and describe their relationship to the Framework.

5. Issues in relation to representation need to be addressed, including the consequences of delay arising from early legal representation.

6. Access to appropriate remediation can prove challenging, and costly, for organisations.

7. Importance of good management skills is crucial when addressing concerns, perhaps a need for training of senior clinicians in this area when Framework finalised.

8. Need to define the use of the word *investigation* throughout the document. May imply formal process when at the beginning of the process we are trying to *establish the facts* in relation to the concern raised.

9. Timescales in Framework require revision as often not achievable in practise.

10. The narrative of processes in the Framework should capture any action taken prior to the formal raising of a concern e.g. the role of the critical friend in having a discussion with a colleague about a concern.

Actions Arising

11. **JL** to circulate DH Remediation Report.

12. **AK** to circulate outcomes of exercise undertaken outlining timescales for MHPS processes.

13. **All working group members** to forward suggested changes and areas to be addressed to PW/JL.

14. **AK** to seek further input from MD's.

15. **All working group members** to forward suggested content for trainee section to PW/JL.

16. Following submission of above, Framework will be further revised and a meeting of the Working Group scheduled to consider. Estimated timescale **January 2012**.

Roberts, Naomi

From: Lindsay, Jane
Sent: 21 November 2011 10:41
To: anne.kilgallen[redacted]; Roberts, Margot; O'Carolan, Donncha; Reid, Simon; kieran.[redacted]; Woods, Paddy; mervyn.barkley[redacted]
Cc: Dardis, Pauline; Davey, Noreen; andrea.armstrong[redacted]; Hutchison, Ruth; Beck, Lorraine
Subject: Revision of MHPS Working Group

Importance: High
Sensitivity: Confidential

Dear Colleagues

Revision of MHPS,Meeting of Working Group, Friday 18th November 2011.

Please find attached a brief summary of Friday's meeting, highlighting key areas discussed and actions arising. Also attached for information is the report of DH's Remediation Working Group that was established as part of their revalidation programme.

Please contact me if you have any queries or suggested changes to the discussion and actions arising notes. We are hoping to make revisions suggested by January 2012, therefore grateful if you could forward your comments and suggestions at your earliest convenience.

Best Wishes

Jane

DH Remediation report - Final ... Revision of MHPS meeting of Wo...

Jane Lindsay
Project Manager-Confidence in Care
DHSSPS,
C3.20,Castle Buildings
Stormont Estate
Belfast BT4 3SQ
[redacted] Mobile [redacted]

Remediation report

Report of the Steering Group on Remediation

Foreword

Whilst the vast majority of doctors maintain high standards it has always been the case that a small minority of doctors have caused concern about their health, conduct, clinical competence and capability, or a combination of these. Health and conduct issues are usually appropriately dealt with locally and when required by the regulator. Clinical competence and capability issues are similarly the responsibility of the employer, the practice and the regulator. However, these have proved far more difficult to resolve, particularly for doctors no longer in training. The focus of the report is therefore to address clinical competence and capability issues occurring in doctors no longer in the training grades.

Revalidation will provide a positive affirmation that licensed doctors remain up to date and fit to practise throughout their career. As part of the annual appraisal process doctors will need to demonstrate how they are meeting the principles and values set out in Good Medical Practice (GMP), the General Medical Council's (GMC) core guidance for doctors.

This guidance is based on the GMP Framework for appraisal. Revalidation is based on this guidance and will form the basis of a standard approach for appraisal. It will demand consistent processes for appraisal, including feedback from patients and colleagues. As such, it is expected that the new system will, over time, help to raise the quality of the medical workforce, by supporting doctors in continually updating their professional skills to deliver a service to patients. However, the new processes will inevitably identify some doctors whose competence gives cause for concern and for whom, if they are to revalidate, some form of remediation will be needed.

The Department of Health asked the Remediation Steering Group to look at how well remediation of clinical competence and capability issues works now in the NHS in England. We were asked to consider whether there are options for improving the way this is managed and delivered, so that doctors can access the support they need when they need it and patient safety can be assured. The Group had a great deal of first hand experience of tackling performance issues. We were also able to draw on both existing materials and research, as well as a survey undertaken especially to support this work.

We found that whilst there was much good practice in managing clinical competence and capability concerns, it was still an area that many employers and contracting bodies found difficult to manage. Providing suitable remediation packages was also challenging and was often difficult and very expensive. Indeed, it appeared that ignoring a problem until it became a crisis, sometimes seemed to be the easiest solution.

The Group developed a set of principles that should be followed when tackling poor performance:

- Patient safety should be paramount;
- Concerns about a doctor's practice must be addressed early, systematically and proactively in all healthcare settings; and
- The appropriate competent authority must take action where a concern is raised.

We considered the factors that will support or undermine how concerns are identified and dealt with through remediation. We developed some options for the future system and for how the complex issues around funding might be taken forward. We have identified a set of practical actions that organisations can take to reduce or prevent the need for intensive remediation or crisis management. Ministers will wish to consider which of the options they wish to explore further.

I have had the privilege of chairing the Steering Group on Remediation. I believe that this report sets out a practical way for improving the current situation. I would like to thank the Steering Group for their time, effort and commitment to taking this subject forward. I am pleased to present this report, which sets out the results of its work.

Professor Hugo Mascie-Taylor Chair, Remediation Steering Group

Steering Group members

Hugo Mascie-Taylor (Chair)	NHS Confederation
Jane Adam	AoMRC (RCR)
Jo Anthony	RST
Iain Barclay	Medical Protection Society
Edwin Borman	BMA
Ailsa Donnelly	PPG RCGP
Mike Cheshire	North West SHA
Anthony Chuter	PPG RCGP
Blake Dobson	GMC
Jackie Hayden	North West Deanery and English Postgraduate Deans
Has Joshi	RCGP
Ann Macintyre	Guys and St Thomas's Hospital
Claire McLaughlan	NCAS
Laurence Mynors-Wallace	AoMRC(RCPsych)
Peter Old	NCAS
Mike Pringle	RCGP
Colin Pollock	Yorkshire SHA
Anna-Maria Rollin	AoMRC (RCoA)
Doug Russell	Tower Hamlets PCT
David Sowden	East Midlands Deanery and English Postgraduate Deans

Observers

Joyce Cairns	Northern Ireland Department of Health, Social Services and Public Safety
Sally Davies	PGMDE Wales
Iain Finlay	Scottish Government

Contents

Executive Summary

The topic of remediation is one of key interest to the medical profession. Although few doctors will have need to access a formal remediation programme during their career, for those that do their ability to get the help they need may well depend on where they currently work and the network of local support their medical director is able to access. The introduction of revalidation for doctors will provide a more structured on-going assessment of clinical performance based on doctors demonstrating they are meeting the principles and values set out in Good Medical Practice framework. This work has highlighted the need to ensure the approach to remediation is more structured and consistent.

The Department of Health sent out a questionnaire to every Trust and PCT in England in December 2009 to understand the scale of the problem and the approaches currently taken to tackling performance concerns. The survey revealed a wide range in how concerns are investigated and remediation delivered. There was also a wide variation in the scale of the problem being managed in each organisation. Respondents also put forward many ideas on how tackling performance concerns could be improved, including many things that NHS organisations could do locally.

In January 2010, the Department of Health established a Steering Group to consider remediation, focussing on managing competence and capability issues. Many members of the Group had considerable personal experience of tackling clinical competence and capability problems and were able to draw upon this experience as well as the Department of Health survey and other recent work in developing their ideas.

In looking at how remediation could be better managed, the Group made six broad recommendations.

1 **performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible;**

2 **local processes need to be strengthened so as to avoid performance problems wherever possible, and to reduce their severity at the point of identification;**

3 **the capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required;**

4 **a single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service;**

5 **the medical Royal Colleges to produce guidance and provide assessment and specialist input into remediation programmes;**

6 **postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are addressed.**

Associated with each of these recommendations are a number of points describing what needs to change. Some of these points are in fact already requirements for those NHS organisations employing doctors, but it would appear they are not always routinely happening. For example, there is already a requirement for the medical director and the human resources director to work in partnership when they are determining the course of action to be taken where there are concerns about a doctor's performance, but the Group noted that there were many instances where this did not happen, especially in the early stages, leading to more complexity and cost in resolving performance problems.

Prevention, as far as possible, was seen by the Group to be as important as improving the way that performance problems are remediated. There is much that organisations can do locally to minimise the occurrence of poor performance and the need for remediation. Good processes that deal with concerns as they arise and systems that support doctors to address their problems have been shown to minimise the need for exclusion and a full remediation programme.

Whilst not in the original terms of reference, the Group heard clear messages from employing and Doctors' organisations that funding for remediation should be more equitable. Currently, most doctors in secondary care have their remediation funded by their trust. Doctors in primary care often make a financial contribution to their own remediation. The Group recognised that there was unlikely to be any new money for remediation and developed a number of ideas for how more equity might be achieved. These will need to be investigated further to determine their feasibility and practicality.

Chapter 1 Introduction

1.1 Patients rightly expect their doctors to remain up to date and fit to practise throughout their career, and capable of undertaking the job they are currently doing. The great majority of doctors expect no less of themselves. However, despite a long and intensive training, there are occasions when some doctors develop clinical competence and capability problems and are no longer able to continue in independent practice. Getting doctors back to full and unsupported medical practice is the aim of remediation. However, whilst the ambition will be to get the doctor back to their previous role it must be recognised that this will not always be possible. Patient safety will always be paramount.

1.2 Representatives of the medical profession told the Department of Health that they felt the way remediation was currently being managed and dealt with across the NHS in England was variable. The need for a good and consistent approach to remediation is independent of the new regulatory process of revalidation that will be introduced by the GMC for all licensed doctors. However, improved clinical governance and the more robust annual appraisal processes which will underpin revalidation may well mean that, at least in the short-term, more doctors are identified who have a clinical competence and capability issue, and are in need of remediation.

1.3 In January 2010, the Department of Health set up the Remediation Steering Group to help develop some options for how remediation could be more effectively organised in the future. The Group consists of representatives from the medical royal colleges, postgraduate deaneries, employers, patient groups, defence organisations, the British Medical Association (BMA) and regulators, most of whom have extensive experience of dealing with performance issues. The terms of reference for the Group are set out in Annex 1.

1.4 Remediation is an issue that has been reviewed recently by a number of organisations including the Department of Health, National Clinical Assessment Service (NCAS), the Academy of Medical Royal Colleges and the Royal College of GPs.

1.5 The Department of Health published the Tackling Concerns Locally (TCL) clinical governance sub-group report[1] in March 2009. This set out 12 principles that should underpin the approach to remediation for health professionals. These are:

1. Remediation must ensure the safety of patients and the public while aiming to secure:
    - the well-being of the healthcare professional and the wider team;
    - the robust delivery of services based on agreed patient care pathways; and
    - consistent competence of the healthcare professional across scope of practice.
2. There should be lay and patient input into the quality assurance and delivery of remediation.
3. Primary Care Trusts (PCTs) and healthcare providers should maintain an available and accessible, quality assured process of remediation for all professional groups.
4. Decisions on remediation should be based on evidence using validated tools for assessment of performance, conduct and health.
5. Remediation should be personalised to the individual healthcare professionals and their learning style.
6. Remediation should be of high quality.

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096492

7. The performance of the professional during and following remediation should be monitored by quality assured methods.

8. The work environment for remedial placement should include adequate, quality assured supervision by a named individual.

9. There should be training and support for the whole clinical team working with the professional undergoing a remedial placement.

10. All those involved in the remediation process should uphold the NHS commitment to equality and recognition of diversity.

11. Remedial training and reskilling must be adequately resourced.

12. Healthcare organisations to define success criteria & learn from experience.

1.6 The Steering Group broadly agreed with these principles, which are set out in full in Annex 2. However, it was clear to the Group that these principles have not been widely adopted by the NHS in England and that in practice some of them would be difficult and expensive to achieve.

1.7 Some research was undertaken to support the TCL work but it was limited in scope, geographical coverage and sample size. However, it did highlight some inconsistencies in the way remediation was delivered. To better inform future policy options it was decided more detailed information was needed from NHS organisations across the country. A new survey was designed, tested and circulated in December 2009. This provided a more comprehensive picture of what was happening across England.

1.8 The findings from the Department of Health remediation survey, and the TCL report along with other recent work on remediation, helped to inform the thinking of the Remediation Steering Group.

1.9 On 12 July 2010 the Government published its White Paper: 'Equity and Excellence: Liberating the NHS'. This set out how power would be devolved from Whitehall to patients and professionals.

1.10 As the quality of information made available to patients improves, it may be that clinical competence and capability issues amongst doctors are highlighted.

1.11 The Remediation Steering Group focussed on how clinical competence and capability issues for qualified doctors currently in clinical practice in England could be better managed. The Group was not required to look in detail at doctors in training, because there is already a process of remediation through the deaneries. The Group did not examine what could happen in the private sector or for doctors working in non-clinical areas (for example medical management, academia or the pharmaceutical companies). These aspects could be explored in the future, although the processes may well be very similar.

Chapter 2 Steering Group

2.1 The Remediation Steering Group was established in January 2010 to look at how remediation might be more effectively managed. The group had a broad membership including employers, human resource departments, deaneries, medical royal colleges, SHAs, PCTs, the BMA, the GMC, the Revalidation Support Team (RST), defence organisations, patient groups, and National Clinical Assessment Service (NCAS). Members of the Group were selected for their direct experience of dealing with doctors with performance difficulties and of instigating or managing remediation programmes. The Group's remit was confined to looking at the provision of remediation in England. The Welsh Assembly, Scottish Government and Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) attended the meetings as observers.

2.2 A number of previous reports and research into remediation provided the background material that informed the discussions of the Group. A survey undertaken specifically to inform this work gave a picture of the current situation in England. This included the views of medical managers about how things might be improved. These are described in chapters 4 and 5.

2.3 The Group met on four occasions and worked in a variety of ways including formal presentations, facilitated discussion and small group brain-storming. An early task was to map out the current process and personnel involved from first raising a concern about a doctor and the many entry and exit points in remediation (see Annex 3). The Group noted that although there were very many ways that clinical competence and capability concerns might be raised, the most usual ways were through peers raising concerns and Serious Untoward Incidents (SUI). In thinking about options for the way forward in managing the remediation process, the Group were mindful of the financial climate and the fact

there were unlikely to be new resources. The conclusions and recommendations from the Group are set out in chapters 7 and 8.

Chapter 3 Remediation

3.1 What is remediation? Dictionary definitions vary, but at its simplest it is an action taken to remedy a situation. In relation to healthcare professionals, the Tackling Concerns Locally report published the following definitions, which the Steering Group took as its starting point:

Remediation: the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.

Reskilling: provision of training and education to address identified lack of knowledge, skills and application so that the practitioner can demonstrate their competence in those specific areas.

Supervised remediation programme: a formal programme of remediation activities, usually including both reskilling and supervised clinical placement, with specific learning objectives and outcomes agreed with the practitioner and monitored by an identified individual on behalf of the responsible healthcare organisation.

Rehabilitation: the supervised period and activities for restoring a practitioner to independent practice – by overcoming or accommodating physical or mental health problems.

3.2 The focus of the Group has been to review how clinical competence and capability issues are dealt with currently, how they could be in the future and how the remediation of doctors should be managed and options for funding. The Group recognised that clinical competence and capability problems may be the result of health or behavioural problems. Health issues should always be dealt with as a priority. Behavioural issues are primarily the responsibility of the employer and should normally be handled through the organisation's human resources and disciplinary procedures. Clarity about which process is being

deployed is necessary at the outset and senior human resource advice is required.

3.3 The Group acknowledged that the word remediation had negative connotations and looked to find an alternative word that might be used instead. This was not achieved largely because the problem is more related to negativity about the actions and processes that arise from a need for remediation, rather than the word itself.

Chapter 4 Development of the current system

4.1 It is said that 2-3% of doctors at any one time may have some sort of clinical competence and capability issue, although there is only limited evidence to support this. The only detailed study into this was done in 1994 by Sir Liam Donaldson who looked at doctors in the North East of England[2]. This found that 6% of all medical staff were involved in some type of disciplinary problem over a five-year period and of these 40% arose largely from clinical competence and capability issues.

4.2 Concerns about the processes used to identify and tackle these doctors have been well documented. *"Supporting doctors protecting patients"*[3] was published by the Department of Health in 1999. It highlighted a set of weaknesses that were inherent in how performance issues were being addressed:

- major problems often surface as a serious incident when they have been known about in informal networks for years;
- over-reliance is placed on disciplinary solutions to problems late in the day, whilst mechanisms to produce earlier remedial and educational solutions are particularly weak. Often the human resource function is not involved until disciplinary proceedings are unavoidable;
- NHS trusts and health authorities are often deterred from taking action because the disciplinary processes are regarded as daunting and legalistic;
- there is no clarity at local level about the interface between GMC procedures and NHS procedures so that there is confusion about who does what and when;
- mechanisms to identify and help sick doctors are unsatisfactory;
- in the past, too many problem doctors have been moved on to become another employer's problem rather than being dealt with; and
- the timescales for dealing with serious problems can be very protracted and often last months or even years.

Source: Supporting doctors protecting patients 1999

[2] Doctors with a problem in the NHS workforce BMJ 94; 308:1277
[3] Supporting doctors, protecting patients DoH 1999

4.3 The report analysed the impacts of the existing processes for dealing with the poor performance of doctors:

- they do not provide proper protection for patients;
- they are not always fair to doctors;
- they are cumbersome and costly to operate; and
- they do not work in support of NHS organisations in their role of delivering high quality health care to the public.

Source: Supporting doctors protecting patients 1999

4.4 It also identified a set of criteria against which the success of any changes might be measured:

- reduction in numbers of patients experiencing harm or sub-optimal outcomes of care due to poor practitioner performance;
- doctors with competency, conduct or ill health problems recognised at a much earlier stage than at present;
- Doctors willing to report their concerns about colleagues;
- confidence of public and patients that the doctor who treats them is well trained, highly competent and up-to-date in their practice;
- patients not put at risk or denied a response to their concerns because the system is finding it too difficult to assess or decide how to resolve problems with a doctor's practice;
- the workings of the regulatory bodies fulfil explicit criteria, easily understood and publicised;
- widely accepted statements on standards of conduct, performance and ethics primarily aimed at the protection of patients;
- a strong effective partnership between the NHS and medical professional bodies to prevent, recognise and deal with poor clinical performance;
- protracted, expensive disputes with uncertainty about how to resolve serious problems a thing of the past; and
- benefits for doctors in the availability of well targeted continuing professional development and support.

Source: Supporting doctors protecting patients 1999

4.5 The report recommended setting up an Assessment and Support Service with a number of centres around England, run jointly by the NHS and the medical profession. This idea then evolved into the establishment of the National Clinical Assessment Authority (NCAA) as a Special Health Authority in 2001. This was

announced in "*Assuring the Quality of Medical Practice"* [4]. The NCAA became the National Clinical Assessment Service, NCAS, in April 2005. It is a legal requirement for NHS health-care providers to contact NCAS when they are considering excluding a doctor from work. NCAS also provides an advice and assessment service to the NHS about any doctor where there are performance concerns. This is currently free at the point of delivery. Further details of the way that NCAS works are set out in Annex 4.

4.6 Since the publication of *"Supporting doctors protecting patients"* a number of other important changes have been introduced that have affected the way that performance issues are identified and dealt with.

4.7 Annual appraisal became a requirement for all NHS doctors in England in 2002/2003. Whilst essentially developmental in nature, appraisal discussions can surface issues about areas of work where there are competency problems, and where action needs to be taken. Personal development plans should include actions to remedy any minor performance issues.

4.8 In 2005 "*Maintaining High Professional Standards in the Modern NHS"* [5] was published. This set out a framework to guide employers of doctors which 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 clinical competence and capability; and
- arrangements for handling concerns about a practitioners health.

It was developed and agreed 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.

[44] Assuring the Quality of Medical Practice DoH 2001

[5] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

4.9 *Maintaining High Professional Standards* is embedded into doctors' terms and conditions for those working in secondary care and for those employed by primary care trusts. These organisations are obliged to use the framework to develop their own policies, procedures and guidance for managing performance concerns and remediation. The Performers List Regulations 2004[6] set out the actions that a PCT must take when it is considering suspending or removing a contracted GP from its list whether for performance concerns or for other reasons.

4.10 In both primary and secondary care NCAS is a resource that the NHS can and does draw upon, although there are a number of other organisations that have also developed a role in remediation.

4.11 Although their main remit is doctors in training, postgraduate deaneries offer some support to registered GPs and primary care trusts through continuing professional development (CPD) programmes. A few deaneries also offer some level of support to doctors not in training but who are in difficulties. Some have confidential help-lines for doctors with health related problems. However, there is no formal basis for them doing so and no specific funding for supporting doctors not in training. Therefore, any remediation activity depends on the personal support of the Dean.

4.12 The medical Royal Colleges set standards and many colleges have assessor pools that carry out reviews of poorly performing teams. They provide advice to employers on standards and courses, but most do not engage directly in remediating individual doctors. However, the Royal College of Surgeons England and Royal College of Obstetricians and Gynaecologists do support employers in designing and implementing the clinical elements of further training

[6] http://www.legislation.gov.uk/uksi/2004/585/contents/made

and return to work programmes where this has been recommended for an individual doctor following a formal performance assessment.

4.13 Medical defence organisations represent individual doctors. They seek to ensure that a member who is facing some sort of proceedings in relation to their professional work is fairly treated and so support doctors in achieving a reasonable outcome. Where members are deemed to present a high level of risk the defence organisation itself may ask them to undertake specific training, which they will have to fund themselves. Some medical defence organisations offer educational courses, open to both members and non-members, particularly focussing on behavioural and communication issues.

4.14 The GMC focuses on fitness to practise. A doctor may be required by the GMC, through a fitness to practise process, to undertake a course of remediation as a condition of remaining on the register. The responsibility to ensure that the remediation happens rests with the doctor and they are re-assessed after any remediation as a pre-cursor to returning to full independent practice.

4.15 There are two aspects to the BMA's involvement in helping doctors where concerns have been raised:

- *Doctors for Doctors* provides confidential counselling for doctors who are facing difficulties, including GMC issues; and
- The BMA also offers a service to advise and support those doctors who have contractual difficulties.

4.16 The current strategic health authority structure can provide some support to medical directors who are dealing with doctors causing concerns.

Chapter 5 Is remediation working?

5.1 Despite the many changes that have taken place since 1999, concern was expressed to the Department by groups representing doctors, including the BMA, individual colleges and the Academy of Medical Royal Colleges, that the approach being taken to providing remediation was not consistent. The perception was that despite setting up NCAS, which assists organisations with assessments and remediation of the most severe cases, many of the underlying weaknesses appeared to be the same as they were in 1999. The success criteria that were identified in *Supporting doctors, protecting patients* as the requirements of a good approach to dealing with performance concerns had not thought to have been met. With revalidation about to be introduced, there is an urgent need for a process that is fair and equally accessible wherever a doctor is based.

5.2 There is a perception that low-level concerns may remain unaddressed for many years. This approach presents obvious risks to patient safety, and risks for the poorly performing clinicians who may not get the support they require until it becomes very difficult and expensive to remediate them. Even at the most severe end of the spectrum, where an organisation is considering excluding a doctor, there are perceived to be delays in the process..

5.3 Whilst there was much good practice, many organisations continue to struggle to recognise and deal with performance problems in a timely and effective manner and found difficulty in accessing appropriate remediation processes. There is a confused picture as to the services colleges and postgraduate deaneries provide. This confusion is thought to be extremely unhelpful, as is the difficulty in securing appropriate remedial placements.

5.4 The Department of Health England carried out a survey of NHS organisations in England between December 2009 to January 2010 to get a current picture of the

way in which all performance problems were managed and, if necessary remediated. The survey also attempted to assess the scale of the problem. A 50% response rate was achieved with a good coverage of all types of trust in most SHA areas. In total 75 primary care and community trusts, 93 acute trusts, and 30 mental health trusts responded. The respondent was usually the medical director or a senior medical manager.

5.5 With a 50% response rate, it was important to do some sort of quality assurance to check the general thrust of the response was representative of the total population of trusts and PCTs. The summary of the quantitative responses for each geographic area was returned to the relevant SHA for review. In all instances this review confirmed that the responses were in line with expectations. This enabled the total number of all doctors currently undergoing remediation in England to be estimated. In addition a large number of suggestions were made as to how existing processes should be improved. The survey is attached at Annex 5.

5.6 The responses confirmed a very varied picture across England as to how concerns were investigated and resolved. There was also variation in the use of different types of remediation processes and different sources of help.

5.7 Over 90% of organisations claimed that they had relevant policies and guidance in place. Over 90% of organisations were confident these were followed. This is in contrast to the situation described in 1999 in *Supporting doctors, protecting patients*, when only a few organisations had any such guidance.

5.8 The number of remediation cases with which any organisation was dealing, at the point the survey was returned, varied considerably from zero to more than 20.

Total number of current cases (at the time of the survey)

	PCT	Acute	MHT
Number:	260	212	27

In total respondents were dealing with 499 cases at the time of the survey. Extrapolating from the 50% response rate these figures suggest that there could be about 1,000 cases being dealt with at any one time in England, covering all types of remediation.

Number of concerns actively investigated over past 12 months

	PCT	Acute	MHT
Number:	753	552	97

Over the past year the respondents reported that 1402 doctors had been actively investigated. Again, extrapolating from this figure, it would suggest around 2,800 doctors have been investigated, representing 2% of all doctors working in the NHS in England.

5.9 Less than 12% of organisations had any specific funds for remedial activities, although nearly 90% of them said that they would make some sort of financial contribution to the remediation of doctors. In acute and mental health trusts it is uncommon for a doctor to be expected to invest financially in their own remediation. Conversely, nearly 50% of PCTs may ask a doctor to make a financial contribution and a third reported they sometimes expected doctors to meet the entire cost. This may reflect the contractual status of a GP as compared with the employee status of a doctor in a trust.

5.10 Only one PCT, three acute trusts, and one mental health trust routinely chose to bring in external support to carry out an initial investigation into a concern. Provider organisations gained support in different way, including NCAS, postgraduate deaneries, medical Royal Colleges and independent companies and wherever possible, internal resources. A range of remedial approaches were used, the most common being mentoring and supervised placements within

the Trust or PCT area. Less than 33% of PCTs and mental health trusts used placements in other trusts. Under 50% of trusts and PCTs used returners' schemes as part of a remediation package.

5.11 A question was asked about the activities that staff in each organisation were trained to undertake. Most organisations had people trained to investigate complaints and assess what action was required. Trained mentors were available in 87% of mental health trusts, 80% of acute trusts and 57% of PCTs. However, only around a third of PCTs and mental health trusts had people specifically trained to provide supervised placements. Only 59% of PCTs, 41% of acute trusts and 27% of mental health trusts had staff trained to assess whether remediation was complete. Since this is an employer responsibility this is a significant issue. Nearly every trust in secondary care involved human resources when there were performance concerns. However, in primary care 33% of PCTs did not involve human resources staff or expertise.

5.12 In addition to the quantitative questions, organisations were asked to contribute ideas about what aspects of the system needed to change to deliver a better way of managing concerns and remediation. They suggested a need for much more consistency in identifying and tackling poor performance. There also needed to be clarity about the roles and responsibilities of different organisations that were active in supporting remediation.

5.13 Organisations thought that much could be done locally to improve the capability to identify and tackle concerns. Recruitment processes were not thought to be as effective as they should be in identifying candidates who had had performance problems in the past, or in picking up problems with new doctors.

5.14 Respondents felt there were still cultural barriers in reporting poor performance. The proposals contained in the recent consultation on Whistleblowing[7] and

[7] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120349

proposed amendments to the NHS Constitution should strengthen the protection given by organisations to whistleblowers. It would also strengthen the expectation placed on staff to raise concerns.

5.15 Organisations identified a need for clear internal processes and local guidance. Better performance data and clinical governance systems should help to produce objective evidence to both highlight concerns and aid review during the investigation of concerns. Training was needed for those dealing directly with the investigation of concerns, human resources departments and medical directors.

5.16 Organisations felt that a single point of external expertise would be helpful, given the relative rarity of clinical capability and competence issues. It would not be possible for every healthcare organisation to become expert in this compex area. The survey suggested that this service needed to be able to access a network of accredited placement hospitals and GP practices to provide supervised remediation placements. More details from the qualitative responses are set out in Annex 6.

5.17 Some other organisations also commented on remediation processes. The Academy of Medical Royal Colleges and the Royal College of GPs were concerned about equity of access to remediation in the context of revalidation. They had set up working groups to look at how the system might be improved.

5.18 The Royal College of GPs completed a short piece of work in autumn 2009[8]. The college supported the four stages of remediation proposed by Tackling Concerns Locally:

- Identifying issues;
- Investigation;
- Deciding on action; and
- Remediation – re-skilling and rehabilitation

[8] http://www.rcgp.org.uk/_revalidation/revalidation_documents.aspx

They set out how each of these might work in a primary care context. The paper proposed that the local primary care organisation (PCO) and deanery should share the cost of remediation themselves and the PCO should meet any other costs. Although currently GPs often contribute to the cost of remediation, the RCGP believed that GPs should be funded to the same extent as hospital doctors. Currently the RCGP does not offer direct support to PCTs dealing with remediation cases, although they are considering providing a practice review service.

5.19 The Academy of Medical Royal Colleges, which represents both medical royal colleges and faculties, set up a working group to consider the potential interrelationship between revalidation and remediation in 2008-09[9]. The group recognised that performance concerns had been unlikely to emerge for the first time at appraisal, but said that appraisers needed to be made aware of any concerns and that these should form part of the appraisal discussion. The group endorsed the principles for return to work set out in NCAS's guidance document Back on Track[10] and the remediation principles set out in TCL. The group considered the direct role of colleges in the remediation of individuals would be limited. They felt there was a direct role for colleges in concerns relating to a team or department, but only an indirect advisory role in relation to individual cases on standards, courses and supervision.

5.20 The AoMRC group made four recommendations for further action on remediation:

1. The Departments of Health in the UK need to establish information about the existing provision of remediation;
2. The Department of Health in conjunction with NCAS should develop detailed guidance on remediation following the introduction of revalidation;

[9] http://www.aomrc.org.uk/introduction/news-a-publications.html
[10] http://www.ncas.npsa.nhs.uk/publications/

3. The Departments of Health in the UK need to explore and evaluate the potential impact of revalidation on remediation programmes; and
4. The provision of remediation should be monitored, maintained, and quality assured to a level where it continues to support appraisal and revalidation.

5.21 In addition to its report on remediation the AoMRC produced a set of scenarios based on real cases, where concerns had been raised about a doctor's practice, and how these might be resolved.

Chapter 6 What does poor performance currently cost the NHS?

6.1 The Department of Health survey did not ask respondents directly about how much they spent on remediation. This was because very few organisations have a budget line specifically for remediation, or have attempted to quantify the full costs. Data was gathered about costs through follow-up interviews with Trusts and PCTs and from information provided by NCAS and the Welsh Assembly Government. The costs associated with dealing with a doctor with performance concerns could be very significant. An initial investigation could cost up to £20,000 per doctor. A placement in another organisation could cost around £60,000 for six months, excluding salary and accommodation costs. Increasingly organisations hosting placements expect to be paid and in addition, there are locum costs to backfill the doctor undergoing remediation.

6.2 The largest type of direct cost arose when a doctor had to be excluded from work. In 2009, 77 doctors in the UK were suspended by the GMC, but during 2009/10 about 108 were excluded by their NHS employer, pending GMC fitness to practice proceedings[11]. Providing cover for excluded doctors is expensive. The cost of locum cover for such doctors could be up to £200k/doctor/year. This is in addition to the salary of the suspended doctor, which in primary care is often paid at 90% of the usual rate and at full cost in secondary care. Waiting for the GMC to reach a decision could push up costs significantly. The sooner problems are identified and successfully tackled the better – both in terms of reduced cost and successful outcome. Annex 7 sets out some indicative costs for remedial

[11] NCAS: Use of NHS exclusion and suspension from work amongst dentists and doctors - 2009/10 mid year report

interventions in primary care and has some case studies to illustrate the problems facing employers and contractors, and the costs involved in difficult cases.

The indirect costs of poor performance

6.4 Department of Health statistics show that about 500,000 patients a year are accidentally harmed in the NHS. The most common cause is patient accidents, such as falls, but there are around 140,000 incidents per year arising from treatments and procedures, or clinical assessment. Although there is no breakdown of why these are happening, some of these are caused by doctor error. 30,000 incidents lead to formal complaints and around 6,500 to litigation.

6.5 The NHS Litigation Authority (NHSLA) was set up as special health authority in 1995 with the principle task of administering schemes to help NHS bodies pool the costs of any loss of or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of their functions. All trusts and PCTs contribute to the NHSLA. In 2009/10 the NHSLA paid out Irrelevant information redacted by the USi in clinical negligence claims. During that year 6,652 new claims were lodged with the NHSLA. Whilst by no means all of these claims can be attributed to doctor error, poor clinical performance is inevitably a factor in some cases and one with a very high cost attached.

6.6 Re-admissions may be an indicator of when medical care has not been achieved first time. According to Dr Foster in 2008/09 the NHS spent over £1.5bn on people being readmitted within a month[12]. Reasons for this included being discharged too soon, or having an additional health problem that was not originally diagnosed. The costs of this can run into hundreds of thousands of pounds for an individual hospital, and in some hospitals readmissions amount to 10% of all admissions.

[12] Dr Foster Hospital Guide 2009

Chapter 7 Conclusions and recommendations from the Steering Group

7.1 The Group concluded that there were a number of key problems inherent in the current system:

- lack of consistency in how organisations tackle doctors who have performance issues;
- lack of clarity about where a personal development plan stops and a remediation process starts;
- lack of clarity as to who has responsibility for the remediation process;
- lack of capacity to deal with the remediation process;
- lack of clarity on what constitutes acceptable clinical competence and capability;
- lack of clarity about when the remediation process is complete and successful; and
- lack of clarity about when the doctor's clinical capability is not remediable.

7.2 In order to address these problems there are a number of actions that need to be taken which can be summarised in the following six recommendations:

1. **Performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible;**

2. **Local processes need to be strengthened to avoid performance problems whenever possible, and to reduce their severity at the point of identification;**

3. **The capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required;**

4. **A single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service;**

5. **The medical royal colleges should produce guidance and also provide assessment and specialist input into remediation programmes;**

6. **Postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are fully addressed.**

These recommendations are expanded in the following paragraphs.

Performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible.

7.3 Employers of doctors, PCTs and, probably in future, Clinical Commissioning Groups are to be responsible for ensuring that annual appraisals take place and that a personal development plan is agreed. They should manage remediation locally whenever possible. Conduct issues should also be handled locally using the local human resources procedures. The new post of responsible officer will have a key role in managing the interface with the regulator.

7.4 Dealing with issues locally does not just relate to the employing or contracting healthcare organisation. Crucially, the individual doctor has a personal responsibility for their conduct, clinical competence and capability and to:

- ensure that they are working to Good Medical Practice;
- working to the relevant specialty framework;
- meet any employment related standards for their current role;
- be honest about when they feel that they might have clinical competence and capability problems and seek early help and support; and
- engage constructively with their employer or contracting body when problems are identified.

7.5 All initial investigations should be carried out by the employer, practice or contracting body:

- health matters should be referred to occupational health or the relevant medical service;
- behavioural matters must be dealt with by the employer;
- clinical competence and capability issues should be dealt with locally in the first instance;
- regulatory matters should be referred to the regulator;
- any criminal matters should be referred to the police;
- there should be a consistent approach to providing remediation, locally delivered as far as possible, with active involvement, where appropriate, from 'expert' organisations.

7.6 The collective NHS has two main responsibilities whether as an employer or contractor of healthcare services:

- responsibility for patient safety, which is pre-eminent; and
- responsibility to support clinicians in meeting their personal responsibility to remain up to date and fit to practise.

Local processes need to be strengthened so as to avoid performance problems whenever possible, and to reduce their severity at the point of identification.

7.7 The Group recognised a large continuum of clinical competence and capability issues, from minor concerns that may be resolved through the annual appraisal and personal development plan process, to issues that require a very comprehensive training package and external assistance.

7.8 Organisations should put in place the following to reduce the risk of performance problems arising and where they do, to identify them at early stage:

- strong medical leadership;
- strong human resource leadership;
- effective recruitment procedures and processes;
- robust annual appraisals and personal development planning;
- consideration should be given to six-monthly review in the first two years following appointment to a career grade;
- normal mentorship for the first two years for doctors newly recruited to career grade posts;
- effective induction processes in place that include organisational ethos (including responsibility to raise concerns about colleagues' practice) and how performance issues are managed;
- promotion of self-referral schemes.

7.9 Once a concern is raised, an organisation should:

- tackle concerns promptly, ensuring the primacy of patient safety;
- fully assess concerns so that appropriate action is taken, following the relevant process;
- fully involve both the human resources director and medical directors who should together lead the process;
- follow an appropriate competent investigation process, including investigation into whether there are organisational issues that need to be addressed;
- maintain good documentation and record keeping throughout the process;
- provide as much information as possible to patients about the processes that are undertaken to resolve concerns that they have raised, whilst respecting

the appropriate confidentiality of the employee, in order that the patient is not lost in the process of investigating and remediating concerns;

- ensure the medical director/responsible officer and the human resources director work together to oversee the processes[13], including reviewing whether there are organisational problems that also need to be addressed;
- make it clear to a doctor who requires remediation what they must achieve before they commit to a programme. This should include clear boundaries, the method to be used for remediation, how they will be able to demonstrate that they have been remediated, how and who will assess whether they have successfully competed the programme, and the proposed timescale;
- ensure that where a doctor causing concern has been recently appointed and promoted, the medical director / responsible officer will liaise with the relevant postgraduate dean to ensure there are no systemic failures in the deanery selection and assessment processes;
- ensure there is a clear exit strategy for any remediation case;
- ensure the remediation process remains as confidential as possible and practicable.
- The Group recognised that many positive initiatives have already been taken locally (e.g. the Wessex Insight project), to tackle clinical competence and capability problems. The approach taken in primary care across Wales gives certainty to GPs about what will happen if they are referred to NCAS and require remediation. This is described in Annex 8.

Capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required.

7.10 The Department of Health survey revealed that many organisations did not have staff trained to deal with all aspects of the process of remediation, from the initial investigation at the point that a concern is identified to the point of assessing

[13] Maintaining High Professional Standards 2005 already mandates such an approach

whether remediation had been successfully completed. To deliver remediation an organisation requires:

- capacity at medical director, human resource director and clinical directors level;
- a pool of competent external investigators available to it;
- the role of responsible officers and their support teams to be closely linked with employers and contractors.

A single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service.

7.11 There should be a single organisation to manage the process of remediation where it is not possible for an employer to do so, either because of the employers lack of experience or more likely, the complexity or the difficulty. This may need to include managing the assessment, retraining and reassessment. It could also include clarifying the funding arrangements, obtaining placements and co-ordinating Royal College input. The organisation would also give advice to employers, contractors and practices, and work to clarify the appropriate roles of other organisations. Clarifying the roles of different organisations in England so there is a coherent framework for managing the remediation of doctors is key to this process.

7.12 No new public organisation should be created to manage remediation processes. The detailed shape and governance of the organisation needs to be defined.

7.13 NCAS currently carries out some of the functions of the managing organisation. At the moment NCAS's services are free at the point of delivery. However, as a result of the Arms Length Body Review it will be required to become self-funding within three years. It may be that other providers will emerge who are equally

placed to carry out the role. They will need to demonstrate the requisite expertise.

7.14 In dealing with cases that the employing or contracting organisation cannot resolve on its own, the managing organisation should:

- provide expert advice to local organisations to facilitate wherever possible, the issue to be resolved locally.
- develop a system for providing and accessing clinical remediation placements;
- source a range of providers that can carry out remediation to an assured standard;
- develop relevant relationships with colleges to provide specialist input;
- establish the mechanisms by which it can be confirmed or not that after a programme of remediation a doctor has met the standard that is expected of them, and can return to full practice; and
- advise on funding arrangements.

The medical royal colleges should produce guidance and provide assessment and specialist input into remediation programmes.

7.16 Few Royal Colleges currently provide full support to the remediation process. However, triggered by the revalidation process they are helpfully producing increasingly clear standards. This is of course in addition to their role in providing education and assessing clinical capability and competence issues through examinations.

7.17 To assure patient safety as well as to support their own members and fellows the Colleges all need to play a full supportive role in the remediation process (recognising that they are neither the regulator nor the employer/contractor).

7.18 The Colleges may also need to provide advice in supporting the remediation process.

7.19 There may be some issues that need to be resolved before all of the Colleges agree to take on this extended role. These include the handling of indemnity issues and the funding required to support the work. Some Colleges have made very considerable progress in addressing these issues and hopefully other Colleges can benefit from this expertise. The Academy of Medical Royal Colleges may have a useful facilitatory role in this regard.

Postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are addressed.

7.20 One of the themes that recurred in the evidence reviewed was that some trainees have successfully completed their training placements despite there being unresolved performance problem involving clinical competence and capability. Clearly any problems arising during training need to be fully resolved prior to accreditation.

7.21 Postgraduate deans have been designated as the responsible officers for doctors in training. As such, they will need to have good exchanges of information with the responsible officer in the organisations where doctors in training are working and with those supervising trainees. In this way, any educational or professional/clinical performance concerns should be raised promptly and dealt with fully. As remediation or targeted training at an earlier stage improves there should be fewer problems later in a doctor's career.

7.22 Postgraduate deans and deaneries may be in a good position to assist in the sourcing of remedial placements for doctors not in training grades, particularly in primary care.

7.23 Postgraduate deans already supervise postgraduate training and oversee the remediation of doctors in training grades. In granting the CCT, they are providing an assurance that each doctor is clinically competent and capable.

7.24 Some deaneries offer advice about remediation for non-training grade doctors. This may, from time to time be helpful, but it is essential that any process should be well documented. It is particularly important that there is clear accountability for the advice offered and any decisions made about return to practise. Some Postgraduate Deans have been particularly helpful in assisting remediation processes, but they cannot act as the employer/contractor or the regulator.

Chapter 8 Funding Options

8.1 Although the funding of remediation falls outside of the Terms of Reference of the Group, it is an important issue that urgently needs to be resolved. In a time of constrained budgets, the case for funding any part of a doctor's remediation needs to be well made.

8.2 Medical training is expensive. Estimates of the total cost vary according to specialty, but a conservative estimate is £250,000 per doctor to reach the point of full registration, which for most doctors is followed by a period of specialist training. A very large sum of money has been invested in each doctor by the time they become a career grade doctor.

8.3 It is not just a question of cost. The time taken to qualify in a specialty is typically around 13 to 14 years after entry to medical school. We therefore have a highly trained workforce who cannot be easily replaced and a demand for doctors which historically has been hard to meet.

8.4 There are a number of reasons why employers have been prepared to invest in the remediation of doctors and will continue to do so in some way in the future:

- public money already invested;
- time and cost of producing an equivalent resource;
- workforce planning assumptions;
- impact of recent legislation, particularly consideration of what constitutes discrimination.

8.5 Decisions on funding need to be fair and equitable and the investment in remediation should be proportionate to the likely outcome. Remediation is about getting back to independent practice, but not necessarily in the same role.

8.6 In some parts of the country, where it is traditionally hard to recruit doctors, employers have an added incentive to fund remediation. However, whether it is appropriate for employers to meet all the costs of remediation, particularly where these are substantial is questionable. There is strong evidence that where doctors have made some sort of personal investment in remediation they are more motivated to follow through to a successful conclusion. In North America it is usual for doctors to pay for both their own assessment and any remediation. In Australia and New Zealand it is the regulator that funds assessment, but clinicians that fund remediation. More information is set out in Annex 10.

8.7 When the Steering Group considered the options for funding remediation, they did so using the assumption that there was unlikely to be any additional money in the system. It also felt that some approaches such as money being held back for remediation by SHAs or the future NHS Commissioning Board, or Monitor were unlikely to work. The Group recognises that there is a need to explore any options in much greater detail. Therefore, it has put forward this series of possibilities for consideration and further investigation.

POSSIBLE METHODS OF FUNDING

Doctor meets all or part of the costs of their own remediation

8.8 Doctors often fund part or all of their own CPD. It might be reasonable to think therefore that doctors should be expected to fund all or part of their own remediation. Not keeping up with CPD might be a factor in the need for remediation so it is not unreasonable to think that an equivalent contribution should be expected to fund any required remediation.

8.9 If this option were routinely used, there might need to be mechanisms to allow some doctors to borrow the money they would need to fund remediation. This could be through a loan scheme, but it might need to be underwritten by the

State because doctors in this situation might be deemed high risk through normal commercial approaches.

Employer funds remediation

8.10 As described earlier in this section, there are a number of good reasons why employers and PCTs currently fund all or part of remediation. However, an open cheque book can bring its own problems. For example, no one would want to see the UK becoming an attractive venue for poorly performing doctors from overseas coming to the UK to access the support that is not available in their own country.

Doctor joins an insurance scheme/extension of indemnity provided by a medical defence organisation

8.11 There are no products currently available, but potentially there could be assistance with the funding for remediation, provided either through an insurance policy or as a benefit of membership of a defence organisation. Medical defence organisations and insurers may deem some doctors just too high risk to cover. Already, the cost of an indemnity premium varies considerably depending on the type of specialty that is practised. Currently, doctors employed in the NHS do not have to meet the costs of indemnity cover. Employers effectively do this, although the indemnity cover only applies for negligence. There might be potential for the employer and the employee to jointly pay into some form of pool, which might be insurance backed. However, this is likely to be resisted by both employer and employee, given the number of employees who might incur significant costs would probably be small and any insurance backed product could well have a prohibitively high premium.

Linking remediation to clinical negligence schemes

8.12 An option that could be explored is making a linkage between remediation and between the costs of remediation and the schemes run by the NHS Litigation Authority. The payments made to the Litigation Authority vary with the risk profile

of each organisation. There may be an opportunity to encourage robust organisation proceses (e.g. recruitment, induction, clinical governance, dealing with complaints etc) by a sliding scale of fees.

Mutuals or subscription clubs

8.13 Mutuals could provide a way of funding and providing remediation in a cost effective way. Groups of organisations would enter into reciprocal arrangements with each other. These arrangements could be in terms of putting money into a pool, based on the number of doctors employed, or providing resources in kind (eg example training placements). A variant on this would be to set up a club on a subscription basis. Being a member of the club could gain you some sort of quality mark and could help to reduce your NHSLA CNST premiums. It would also gain you access to support from the managing organisation and appropriate college and deanery input. Such an approach might have attractions for the private sector too.

Contribution of the private sector

8.14 Whilst the Group did not look at the private sector in terms of access to remediation, the Group noted that currently the private sector does not make any contribution to the remediation of any doctors that worked for them who also worked in the NHS. This was something that the Group thought needed to change as the private providers were benefitting from the investment of the NHS.

8.15 It is for Department of Health to consider which of these options it wishes to explore further.

Chapter 9 Other considerations

9.1 The new role of responsible officer came into force on 1 January 2011. All designated organisations employing doctors, including all NHS and private healthcare providers, now have to appoint a responsible officer. The responsible officer will be accountable for managing the revalidation process when it is introduced. During 2011, the responsible officer will ensure that their organisation's clinical governance and appraisal systems are sufficiently robust to support revalidation and that there are clear processes in place for dealing with performance concerns. The designated organisations must provide responsible officers with appropriate support to carry out their functions.

9.2 Although most responsible officers are likely to be existing medical directors, a specific training package has been developed to help prepare responsible officers for carrying out their functions. This will be delivered from early 2011. It will provide an opportunity to help embed some of the actions proposed by the Group for improving local systems for managing the remediation of poorly performing doctors. In addition, all medical managers need training for their role as managers of other doctors. This includes training in the associated human resources and performance frameworks in operation in their organisation and in particular in regulatory and employment matters.

9.3 There will be occasions when, despite all best endeavours, it will be necessary to conclude that a trainee or a qualified doctor should no longer practise and that remediation cannot be achieved. The Steering Group believes that there needs to be more work with the GMC to agree how to improve the management of these situations.

Annex 1

Terms of reference for the Remediation Steering Group

1 To review and confirm the principles of good practice on remediation set out in the report of the Clinical Governance sub-group of Tackling Concerns Locally.

2 To review the research on the current approach to the provision of remediation for doctors in England and identify whether there is other information that needs to be collected.

3 To review evidence on the cost-benefit and value for money of early remedial interventions, at both the organisational, patient and individual doctor level.

4 To assess the demand for remediation including any potential impacts deriving from the processes underpinning revalidation, such as improved clinical governance and strengthened medical appraisal, and look at the potential cost and resources impacts.

5 To make recommendations on the models and structures for delivering remedial services in England.

6 To confirm that additional operational guidance is necessary for healthcare providers about how to identify the need for and ensure access to remediation for doctors, and to help develop the specification for commissioning the guidance

7 In taking forward its work, the Group will bear in mind the definition of remediation set out in *Tackling Concerns Locally*: “the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.”

Annex 2

Recommendations for the Tackling Concerns Locally Report

1. Remediation must ensure **the safety of patients and the public** while aiming to secure:
   - the **well being of the healthcare professional and the wider team**;
   - the **robust delivery of services** based on agreed patient care pathways; and
   - **consistent competence of the healthcare professional** across the entire scope of their practice.

2. There should be **lay and patient input into the quality assurance and delivery of remediation**. This could for instance involve a "lay champion" of healthcare professional performance at the level of the trust board. In addition, patients under the care of a professional undergoing remediation should be informed.

3. Primary Care Trusts (PCTs) and healthcare providers should maintain an **available and accessible, quality assured process of remediation for all professional groups** as an integral part of their local performance processes. A senior executive team member of the organisation should be responsible for the implementation and quality assurance of these processes and there should be regular reports to the board on the progress of individual practitioners. Self-referral by practitioners should be encouraged.

4. Decisions on remediation should be based on evidence using **validated tools for assessment of performance, conduct and health**. This would include assessment of behaviour at work, functioning in the clinical team, clinical competence, feedback from patients, assessment of the work and organisational environment, and any underlying health issues.

5. Remediation should be **personalised to the individual healthcare professionals and their learning style**, with explicit goals and timescales that are proportionate to the risks to patient safety. The possible need for a clinical placement away from the normal place of work should be considered. Resource needs, and the relative contribution of the healthcare organisation and the professional for funding, should be agreed out the outset.

6. **Remediation should be of high quality.** All involved in providing remediation should be competent in relation to the process as a whole and expert in their own field. There should be clear, accurate and comprehensive documentation of all processes and meetings. Processes should respect confidentiality both of patients and of the professional.

7. The performance of the professional during and following remediation should be **monitored by quality assured methods**, focussing on the attainment of

planned goals. A designated individual should be appointed by the healthcare organisation to oversee and support the professional, both during remediation and during the transition back to unsupervised practice at the end of the remediation process. The responsible person should regularly review whether the plan still adequately protects patient safety or whether other action (eg referral to the national regulator) is necessary.

8. The **work environment for remedial placement should include adequate, quality assured supervision by a named individual.** The environment should reinforce the values of patient centred care. The relative responsibilities of the placement supervisor and of the individual responsible for the general oversight of the practitioner (see principle 7) should be clearly specified, including an agreed system for reporting any concerns arising out of the placement.

9. There should be **training and support for the whole clinical team working with the professional undergoing a remedial placement**, while maintaining confidentiality over discussions between the professional and those responsible for oversight of the process.

10. All those involved in the remediation process should **uphold the NHS commitment to equality and recognition of diversity**.

11. **Remedial training and reskilling must be adequately and appropriately resourced**. Healthcare boards must have a senior member responsible for the resourcing and operation of performance procedures who can make the case for investment in remediation, including sufficient capacity for clinical placements. This will involve effective partnership working with postgraduate deaneries/higher education institutions approved by the relevant regulatory bodies, and with other local healthcare organisations.

12. Healthcare organisations should **define success criteria and learn from experience.**

Annex 3

Remediation journey

IN

1 Entry

i Triggers

a. Monitoring clinical governance and audit data (and other relevant data)
b. Police
c. OH/GP (thresholds issues)
d. Complaints etc
e. Incidents
f. Whistleblowing
g. Peer review
h. SUIs/SEA
i. Revalidation/appraisal

ii Referrers

a. Self-referral
b. Colleagues
c. Friends and family
d. Employers
e. PCTs
f. ROs/MDs
g. Medical examiner
h. GMC
i. Deanery system/ARCP
j. Pharmacists/dispensers
k. Counsellors
l. Coroner's reports/Rule 43 letters
m. Child protection services
n. Social care cases
o. Media
p. Undertakers
q. Schools
r. PALs

EXIT

2 Scope the problem (most difficult problem)

a. Context review
    i. personal/non-personal
    ii. Team environment/individual
b. Identify manager

EXIT

3 Diagnostic process based on the medical model

a. History
   i. Personal
   ii. Team environment

b. Investigation
   i. Health/clinical competence and capability/conduct?
   ii. Is this person equipped for the job or not?
      1. OH (including cognitive assessment)
      2. Psychometric/behavioural issues
      3. Clinical performance
      4. MSF

c. Diagnosis and prescribing

EXIT

4 Intervention (or not)

EXIT

5 Interventions (not necessarily linear)

Types of intervention

- Advice
- Education and training – including re-skilling
- Coaching – behavioural change
- Mentoring
- Supervision
- Placement
- Work based assessment/learning assessment
- Team based approaches (in isolation or with others)
- Return from ill health

Dependencies (policy environment a key factor):

- Resources
  - Capacity in all its constructs
  - Finance
  - Engagement of doctor
  - Insight of doctor
- Other identified factors (non personal)
- Institutional culture]
- Willingness to retrain doctor
- Need for 3-way contract between doctor/employer/provider

EXIT

6 Post intervention review

Needs to be an external review

Actions

- Post-intervention analysis of accumulated evidence (self-assessment included)
- Decision-making – not just either/or
- Doctor to collect evidence of progress
- Ongoing review of progress

Conclusions

- Final outcomes (several possible)
    - Back to same job
    - Back to adjusted job (new employer/role)
    - New job
    - GMC (involuntary out – at moment no honourable voluntary out)
    - Voluntary out

[Dependencies similar to interventions]

EXIT (possible re-entry)

Annex 4

National Clinical Assessment Service (NCAS)

NCAS was established specifically to help resolve concerns about a practitioner's performance for which organisations needed external support. It offers advice, specialist interventions and shared learning. In terms of direct support for individual practitioners NCAS receives around 900 referrals a year about doctors, dentists, and pharmacists. The majority of referrals are about doctors. With around 150,000 doctors and 30,000 dentists working in the UK, each year the performance of about one doctor in 190 causes enough concern to result in an NCAS referral. For dentists the one-year referral rate is about one in 290. (Pharmacists referrals are a new work strand and therefore it is too early to comment on the referral rate.) These figures have not changed significantly since NCAS was set up. About 1 referral in 17 leads to a formal NCAS assessment being undertaken.

The assessment process is an intensive examination of a doctor's practice. The validity and reliability of an NCAS assessment depend on sampling across a practioner's practice using a wide range of instruments including:

- Occupational health assessment
- Behavioural assessment
- Review of information provided by the referring body and practitioner
- Records review
- Case based assessment
- Direct observation of practice
- Interview with the practitioner
- Feedback from colleagues and patients
- Review of the working environment
- Simulations (if necessary)

In addition to providing direct support to organisations, NCAS publishes a range of practical publications to help organisations deal with performance concerns effectively. Among these, Back on Track[14] 2006 addresses the retoration of practioners to safe practice and sets out seven guiding principles for employers in formulating their return

[14] Back on Track NCAS 2006

to work programmes. NCAS also undertakes an extensive programme of education and training for the NHS.

Annex 5

The Department of Health would like your help in providing a full picture of how Trusts and PCTs are currently responding to the need for remediation measures when there are concerns raised about a doctor.

For the purposes of this questionnaire, "concerns" means concerns about a doctor's conduct, performance or health related issues. These "concerns" may come to light in a number of ways, for example raised by the doctor, raised by another healthcare professional, resulting from analysis of clinical information, or raised by patients or their relatives.

Remediation was defined by the 'Tackling Concerns Locally' Programme[15] as the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.

The information you provide will help us to build a baseline picture of current remediation provision across England and what steps should be taken to ensure that all doctors have access to appropriate support when the need arises.

Completing the questionnaire will take approximately 15 minutes. Thank you so much for taking the time to contribute to this important exercise.

The first two questions focus on your organisation

1. **My organization is a:**
   - **PCT**
   - **Acute Trust**
   - **Mental Health Trust**

2. **My organization employs**
   - **0-50 doctors**
   - **50-100 doctors**
   - **100- 300 doctor**
   - **Over 300 doctors**

The next set of statements focuses on how concerns are raised and dealt with initially

3. **The Trust/PCT has a clearly defined process for health care professionals to follow when raising concerns about a doctor in this organisation.**

[15] Tackling Concerns Locally: report of the Clinical Governance subgroup, DH, March 2009.

- Yes
- No

4. **The Trust/PCT has developed a policy that describes the immediate action to take when a concern is raised about a doctor.**
   - Yes
   - No

5. **The Trust/PCT has guidance in place that helps managers to start to deal with a range of concerns.**
   - Yes
   - No

6. **I am confident that the Trust/PCT policy guidelines are followed when responding to any concerns raised by health care professionals about a doctor.**
   - Strongly Agree
   - Agree
   - Slightly Agree
   - Cannot say
   - Slightly Disagree
   - Disagree
   - Strongly Disagree

7. **Do you think that the existing appraisal systems for doctors within this Trust/PCT are sensitive enough to provide early identification of any performance, conduct or health issues?**
   - Yes
   - No

8. **Staff recruitment and selection procedures reliably identify any conduct, performance issues of doctors seeking employment within this Trust/PCT.**
   - Strongly Agree
   - Agree
   - Slightly Agree
   - Cannot say
   - Slightly Disagree
   - Disagree
   - Strongly Disagree

9. **The Trust takes swift action after a concern is raised about a doctor, if a risk is identified.**
   - Strongly Agree
   - Agree

- Slightly Agree
- Cannot say
- Slightly Disagree
- Disagree
- Strongly Disagree

The next set of questions looks at how the concern is currently dealt with

10. How does the Trust/PCT carry out an initial investigation following concerns bring raised about a doctor?
- Internal resources
- Seeks external support from another specialist organisation

11. Following an initial investigation, and where further action is required, how does the Trust/PCT go about assessing what action is required?
- Internal resources, including HR
- NCAS
- Deanery
- Royal College
- Commission other external provider

12. Where a programme of remediation is identified as being necessary for a doctor, who provides this programme for your Trust/PCT?
- Internal resources
- Deanery commissioned programme
- Other external provider

13. What kind of remediation activities do you currently use in your Trust/PCT?
- Mentoring
- Returners induction schemes
- Supervised placements within your Trust/PCT
- Supervised placements in another Trust/PCT
- Deanery based schemes
- Other educational courses
- Healthcare support

14. How many remediation cases are you currently dealing with?

15. What future plans do you have for remedial services in your Trust/PCT?

Thinking about the funding of remediation in your organisation.

16. Do you have a dedicated budget for remedial activities in your Trust/PCT?

- Yes
- No

17. How are funds provided for the remediation of the doctor?

- Funds are found from within the Trust/PCT
- The Deanery pays for the remediation
- The doctor makes a contribution towards the remediation costs
- The doctor pays for their own remediation

Thinking about those within your organisation who are having to deal with concerns and remediation

18. Are people within your Trust/PCT trained to undertake:

• Investigation of complaints	Yes	No
• Assessing what action needs to be undertaken	Yes	No
• Provision of supervised placements	Yes	No
• Mentoring	Yes	No
• Assessing completion of remediation	Yes	No

19. Is the HUMAN RESOURCES DEPARTMENT department actively involved in the process when a concern is raised about a doctor working in the Trust/PCT.

- Yes
- No

20. Is Occupational Health is actively involved in the process when a concern is raised about a health care professional working in this Trust.

- Yes
- No

We would like your opinions about important developments

21. In your opinion, what are the two most important developments that would improve the processes and outcomes for raising conduct, performance or health concerns about doctors in your Trust/PCT?

Enter your text in the space provided:

22. **In your opinion, what are the two most important developments that would improve the Trust's processes for dealing with the remediation of doctors working in your Trust/PCT?**

    Enter your text in the space provided:

23. **How many concerns have been actively investigated in your Trust over the past 12 months?**

24. **If you have any further comments about the issues in this questionnaire, or any issues that you believe have not been addressed, please outline your comments in the box below:**

    Enter your text in the space provided::

Name:

Organisation:

Thank you so much for taking the time to complete this questionnaire

Annex 6

Qualitative questionnaire ideas

Those that responded to the survey thought that there was a lot that they could do to improve patient safety and to improve their own systems by putting in place mechanisms to help identify problems early:

- improved human resources department processes, particularly at the primary care level;
- better documentation of concerns as they arise until their resolution;
- ensure that consultants were clear about their responsibilities as line managers;
- existing recruitment processes were highlighted by many organisations as inadequate in flagging up performance problems. Ideas to address this included:
  - asking for three previous appraisal summaries
  - psychological profiling of candidates
  - compulsory induction process
  - assessed probationary period;
- address cultural problems in raising concerns:
  - make it clear that all staff have a duty to raise a concern
  - protection for whistleblowers
  - organisations to have processes in place to ensure that concerns raised are taken seriously, and not dismissed because they come from more junior staff or non-medical staff; and
- try to de-stigmatise remediation:
  - reposition it by recognising that there will be times throughout most people's career when they will have a need to improve and update their skills
  - support and promote self-referral.

Lack of hard evidence was viewed as one of the main problems in the early and clear identification of performance problems. There was a need for:

- good benchmarking and quality data that could relate to individual clinicians;
- Improved clinical governance, including the development of outcome measures and monitoring of such measures; and
- For GPs having individual prescribing numbers would be a positive step. Currently, locums and many salaried GPs don't have their own number but use a partner or generic practice number.

Whilst opinion was divided about whether appraisal currently identifies poor performance, respondents felt that the introduction of a more consistent approach to appraisal in support of revalidation would routinely identify more performance problems. This needed to be linked to consistent follow-through by managers on the issues raised.

Tackling poor performance

Organisations recognised that their own staff needed to be better trained in tackling poor performance:

- specific skills training, for example how to conduct an investigation and mentoring;
- workshops for clinical directors and human resources department departments to reinforce the processes that need to be followed; and
- better alignment between medical management and HR management about how performance issues should be tackled.

Many of the external bodies that already had a role to play in remediation could do so more effectively:

- The BMA should be more available to members and liaise more closely with employers and PCTs when a concern is first raised;
- NCAS needed to be speedier, more accessible, and offer support services that do not involve a formal NCAS assessment;

- Response times from the GMC should be much faster;
- The Colleges should give a better service and provide clearer guidance about what represented unacceptable practice;
- The role of Deaneries should be strengthened, and dedicated resource available for remediation; and
- Occupational health services needed to be improved as the quality and clinical competence and capability was varied.

Respondents felt that there was a need for the development of regional expertise that organisations could call upon, as it was not cost-effective for them all to become experts in this area. This might take the form of lead hospitals and GP practices that could offer supervised placements, a pool of trained remediators, or remediation consortia being set up. Another suggestion was a network of investigating officers in each region that can be called upon as required.

It was felt that concerns should be classified, as should the approach that is taken to dealing with them, so that there is clarity about the pathway that will be taken to resolve them and which organisations will be involved. For low-level concerns, the emphasis should be on learning rather than punishment, but progress in addressing all concerns should be properly monitored.

Funding was an issue raised by many organisations. The lack of explicit funding was seen as a barrier to tackling performance concerns properly, both in terms of training staff to deal with it and in terms of access to suitable packages of remediation. Whether a doctor should contribute financially to their own remediation was not seen as so much of an issue as the fact that there was no clear central policy about whether they should do so or not.

Annex 7 – Indicative costs

Indicative costs for different types of remediation activities for GPs:

- Initial occupational health assessment by consultant specialist – circa £300
- Initial reviews- circa £2000
- Full diagnostic package including visits and preparation of the report and initial support: 1 to 1 ½ days = £1200 to £2000 (exact costs will depend on the variety of assessment tools used)
- Validated knowledge based test such as the Applied Knowledge Test which is part of the new certifying exam for GP s or Clinical Skills Assessment tests and Multiple Choice Questions this would cost an additional £400 – 500 per attempt.
- Additional support/mentoring meetings = £300 per meeting (lasting 2 hours including preparation time) or circa £2500 for a 3 month period involving 10 contacts.
- Remedial education (will depend on need eg tutorials, courses etc)
- Communication skills training circa £500
- Behavioural therapy through mentoring, role play and personal development would be variable.
- Re-assessment costs to determine improvements and if doctor or dentist is likely to be safe to practise
- Provision of placement in an advanced training practice is required in a small number of cases and has more financial significance. An example of such costs would be placement for supervised consultations with ongoing monitoring and reports. This would cost circa £15,000 for 4 months where an experienced clinician would be dedicating about 8 hours per week of their time + provide ongoing supervision and consulting surgery expenses etc.
- Training courses would incur variable costs, depending on their length and nature.

Source:
Wales Deanery

Case study: A district hospital in the north of England

"The case was prompted by a SUI report. This led to an inquiry within the hospital. It concluded that there was a case to answer by one of the doctors. The medical director then took advice from NCAS and the doctor was removed from out-of-hours duties. A locum covered the out-of-hours work over a period of two years with an associated cost of c£150,000. After the NCAS assessment it was agreed that the doctor should have a six month placement in a neighbouring teaching hospital. The trust paid for this at a cost of £50,000. The placement was successfully concluded, but on return the doctor felt the other consultants were hostile towards him and the doctor has now gone to a neighbouring trust on a six-month contract. After this he will have to return, or attempt to find a job somewhere else. The indirect management costs associated with this case have not been quantified. "

Case study: A PCT in the north of England

"There are a number of GPs in performance procedures who need to work in a practice where they can be supervised. At the moment the PCT funds this as there are severe recruitment problems in the area. Such GPs are paid at the lowest rate for GPs which amounts to about £90,000 per year with on-costs. Normally placements last three to six months. The clinical supervisors overseeing the placements feel they should be additionally rewarded and they are paid about £9,500 for six months. If the GP then needs to have a local action plan, this will require an educational supervisor (paid at training grant level), a mentor (£60/hr) and a PCT supervisor. The overall package for six months can be £75,000."

Case study: A London hospital

"One doctor has recently been through a five-year programme, which has still not ended. There were issues around competency and behaviour. Eventually a placement was found for him at a neighbouring hospital. It was not a very good experience for them and they are unlikely to take anyone else from our hospital. Working with this doctor has cost us hundreds of thousands of pounds. There is another surgeon that we can't find anyone else to take. There needs to be a more formal system to take people for retraining."

Annex 8 - Best practice examples

Welsh model

In Wales, when GPs are referred to NCAS or the GMC and have restrictions placed upon their practice and an action plan, this may include a placement in an advanced training practice. These are practices that have been rated as excellent in terms of the training they provide and that have trainers who have undertaken specialised training. The advanced trainer will be a dedicated resource for the GP in difficulties and will not be supervising trainees at the same time.

There are 18 ATP Practices and 33 ATP trainers. Money flows directly from the Welsh Assembly to the Deanery for the training of the trainers. A placement in an advanced practice usually last six months. The money for the placement will come from the Local Health Board (LHB) and/or from the doctor. The patients are told that there are being seen by someone who is re-skilling, but they are very carefully supervised so it seems to be accepted. In addition, the doctor will be expected to spend a day a week undertaking clinical audit or CPD related activities.

Regular monthly reports are made on each doctor under supervision. At the end of the placement the trainer makes a report to the LHB and to the Performers Group. If the conclusions is that they should not be working they are removed from the Performers List. If the assessment is satisfactory they go back into their practice.

The system normally works well and doctors are motivated to return to full practice. The same approach is also used for returners in primary care, this is deemed to be someone who has been away from work for at least two years. There is recurrent funding for a combination of UK returners and EEA inductees (up to a maximum of 9 at any one time) from the Welsh Assembly Government.

Tiered approach in a London hospital

The Trust takes a tiered approach to dealing with performance concerns:

- Low end – agree a care plan with the doctor.
- Medium severity - a structured learning contract must be committed to by the doctor.
- High-end more formal disciplinary procedures commenced.

Concerns are dealt with as they arise which means that very few need to be escalated to the GMC and fitness to practice procedures. Where people remediation it is usually repositioned from a disciplinary procedure to a supportive one to positively drive improvements. A pastoral philosophy underpins the way underperformance is managed, whilst ensuring that patient safety is the top priority.

Junior doctors in difficulty are looked after by the Deputy Director of Education and where necessary Deanery support is sought. A confidential service has been put in

place to encourage juniors to come forward where they think they have difficulties. Every six months the Deputy Director of Education makes a report to the Board about the outcomes of remedial interventions for junior doctors.

The medical director deals with consultant graded. Most cases are dealt with through local management, although on occasion it is necessary to seek an external placement.

The Trust believes that strong leadership is required to make remediation work. The medical director must make a record of soft intelligence so that it can be linked with hard data from of Serious Untoward Incidents (SUIs), complaints, other incidents and audits.

The routine analysis of SUIs and complaints is a really important part of managing performance. When there is a problem the Medical Director has an initial chat with those involved. If a lack of proper process in the system is identified, which exposes junior staff, the consultant in charge of that area will be given the task of resolving the process gap and given a learning contract to complete this.

Within the Trust there is considerable investment in medical leadership with a consultant leadership programme in place. This helps to create a supportive community with the long-term interests of the organisation at its heart.

A clear grievance and disciplinary policy is in place setting out exactly what will happen when. Everything is fully documented so that there is a clear audit trail. A medical workforce clinical manager is in post to manage the processes.

This very systemised approach has led to savings with most of the remediation either being provided through in-house mentors or through the organisational commitment to providing further education.

Wessex Insight
A proactive approach to performance issues has long been part of the way Wessex Deanery works. Through this it was recognised that a number of doctors in the area had in fact been struggling for some time. It was felt that something more was needed to support individuals to address their problems before they became formal performance matters. This gas been taken forward through a virtual organisation “Wessex Insight”. The LMC is prepared to fund 50% if doctor agrees to put in the other 50% so that they have both made some investment in the future. This fund covers brief non-health related interventions and covers both knowledge gaps and organisational matters such as time management, consultation skills and decision-making skills. There is a set format for the intervention, an assessment with the medical director followed by an educational assessment with the Deanery and then developing an action plan. An SLA is in place with the Deanery. “Wessex Insight” started on 1 April, and doctors are engaged in the process. Literature has been sent to appraisers, as it is felt that many of the problem areas are likely to emerge through the appraisal discussion. The scheme has been promoted by e-mail to individual doctors. The LMC will use income generated

through its appraisal contracts with the Channel Islands to fund this initiative. A cap of £2k per doctor is envisaged. The project will be evaluated on an on-going basis. A questionnaire has been developed for participants to be used at the beginning and end of the process.

Zero tolerance – a PCT in the West Country

"We have a relatively high number of concerns because there is a very good system in place to pick them up, including behavioural issues. Attitudinal problems are simply not tolerated. The PCT has a very low threshold compared with other areas and this has been confirmed through case reviews with neighbouring PCTs. There is some hostility amongst practices for the robust approach taken by the PCT, but a very good response from patients. Leaflets are sent out about how to raise a concern to all those who are joining the performer's list. At the PCT level, there are clear policies and guidance which is followed when we investigate a concern, and the policies are frequently reviewed. Our approach is helped by the stable team at the PCT. If required the Deanery helps doctors to find suitable placements."

Annex 9 - Practitioner Health Programme

In 2008, a pilot scheme called the Practitioner Health Programme was set up in London. It derived from the Chief Medical Officer's report on medical regulation *Good doctors, safer patients* (2006)[16]. The Practitioner Health Programme is a free and confidential service for doctors and dentists living or working in the London area (within the M25) and who are suffering from mental health, addiction or physical health problems that are affecting their work. These groups may face a number of barriers when dealing with health difficulties, particularly mental health and addiction problems. For example:

- the insight of sick practitioners into their condition and the impact that it has upon their performance may be severely compromised
- illness in practitioners may be poorly managed and appropriate assistance may not be sought for a variety of reasons
- practitioners may be able to disguise their illness from others (perhaps through self-prescription)
- where illness is recognised to adversely affect performance, there may be a reluctance to refer a practitioner into a system that is perceived as "disciplinary", particularly where there is a lack of knowledge as to alternatives
- an excessively stressful work environment may have a significant impact on a practitioner's health and wellbeing.

Practitioners may not wish to access mainstream services for a variety of reasons, including an unwillingness to admit to illness, concerns about confidentiality, opportunities for self-medication and inappropriate treatment when they do access services.[17] Studies show high rates of depression, anxiety and substance misuse in healthcare professionals, especially doctors. Suicide is higher in doctors and dentists than in the general population[18]. In the first year of operation the NHS Practitioner Health Programme helped more than three in four of the 184 clinicians seen by the Programme to stay in or return to work.

[16] Good Doctors safer Patients
[17] National Clinical Assessment Service (NCAS), 2007
[18] Harvey et al, 2009

Annex 10 Approaches in other countries

- Canada and USA have a very different approach to managing the performance of doctors. Both countries not only have a system of state regulation but also a very tight set of rules connected with the appointment of doctors in hospitals. Contracts and clinical privileges are renewed either annually or biannually and a pre-scribed set of evidence needs to be produced in support of an application to continue practice within the hospital or to work there for the first time. Most doctors who work in the community also have some sort of hospital post.

- Assessment and remediation programmes are offered by a range of providers, both in the university and private sectors. It is usual for the doctors to meet the cost of any remediation programme themselves and for some or part of the assessment process

- The Vanderbilt distressed physicians programme is a well-established 5-day programme to help doctors learn to manage their workplace behaviour. It costs $4000, following an assessment. The programme is run in other centres in North America and will be piloted this year by Oxford Deanery

- The Queensland Government in Australia has set up the the Clinician Performance Support Service (CliPSS) to provides support and advice for the management of concerns about the safe clinical practice of individual clinicians. CliPSS has been established as the primary referral pathway when there are concerns regarding patient safety as a result of job performance. It was designed as an alternative non-adversarial method for the management of serious clinical performance issues, but does not cover health related issues

- In New South Wales the Performance Program, was introduced in October 2000. The Medical Council of NSW aims to ensure practitioners' fitness to practise, and the Performance Program is central to this aim. The Program is designed to complement the existing conduct and health streams by providing an alternative pathway for dealing with practitioners who are neither impaired nor guilty of professional misconduct, but for whom the Council has concerns about the standard of their clinical performance. The program is designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is properly protected. It is designed to address patterns of practice rather than one-off incidents unless the single incident is demonstrative of a broader problem.

Annex 11

Remediation plans in the Devolved Administrations

Remediation support in Scotland for Doctors and Dentists

At the moment a service level agreement exists between the Scottish Government and NCAS to facilitate the provision of confidential assistance and independent advice, support and assessment to NHS Scotland boards in respect of medical or dental practitioners for whom performance concerns have been identified. This SLA has been operating since 2008, and is presently under review to ascertain if it remains appropriate for the future needs of NHS Scotland.

In preparation for medical revalidation, pilot activity to enhance appraisal of doctors is well-developed, including scoping what remediation support may need to be provided to support this process. The intention is to discuss emerging proposals at the SGHD-led Regulation event in October with a view to achieving consensus on such support to support enhanced appraisal systems in time for implementation in 2011 [DN need to update after the event].

NHS Lothian are currently undertaking a pilot project in Edinburgh in relation to remediation called “Tackling Concerns Locally”. The purpose of the pilot is to test out an approach to the investigation and management of concerns locally with a view to producing a framework for use across NHS Scotland. This pilot is due to be completed in December 2010. However, an update will be provided at the Regulation event in October.

Wales

The Wales Revalidation Delivery Board is Chaired by Dr Jane Wilkinson, the Deputy CMO and reports to the UK Revalidation Delivery Board. The Board has been charged with developing four workstreams namely: appraisal, IT provision required for revalidation, Responsible Officer and Remediation and Rehabilitation. The latter workstream is led by Dr Sally Davies, SubDean (Performance) at the Wales Deanery. This workstream was established in October 2009 and received funding from the Wales Assembly government for the appointment of an executive officer.

The first phase involved stakeholder interviews across Wales, undertaking a literature survey of causes of performance issues in doctors and existing evidence for remediation, a survey of support available across the Health Boards and Trusts in Wales, and identification of best practice and gaps in provision. The work is regularly reported back to the Delivery Board. The next phase will be to undertake a pilot in Wales to complement those pilots already underway in England.

Northern Ireland

The Department of Health, Social Services and Public Safety (DHSSPS) is currently reviewing it's guidance in relation to remediation and rehabilitation to reflect the revalidation process, the role of Responsible Officers and recommendations from the final reports of the Deparment of Health Tackling Concerns working group.

A key principle in the revision of this guidance and its implementation is that remediation and rehabilitation must ensure the safety of patients and the public while ensuring the wellbeing of the healthcare professional. In progressing this work, DHSSPS are committed to engaging with key stakeholders including doctors, Responsible Officers, the General Medial Council, and healthcare providers to ensure that changes in guidance will be successfully implemented and will be effective.

Remediation report

Report of the Steering Group on Remediation

Foreword

Whilst the vast majority of doctors maintain high standards it has always been the case that a small minority of doctors have caused concern about their health, conduct, clinical competence and capability, or a combination of these. Health and conduct issues are usually appropriately dealt with locally and when required by the regulator. Clinical competence and capability issues are similarly the responsibility of the employer, the practice and the regulator. However, these have proved far more difficult to resolve, particularly for doctors no longer in training. The focus of the report is therefore to address clinical competence and capability issues occurring in doctors no longer in the training grades.

Revalidation will provide a positive affirmation that licensed doctors remain up to date and fit to practise throughout their career. As part of the annual appraisal process doctors will need to demonstrate how they are meeting the principles and values set out in Good Medical Practice (GMP), the General Medical Council's (GMC) core guidance for doctors.

This guidance is based on the GMP Framework for appraisal. Revalidation is based on this guidance and will form the basis of a standard approach for appraisal. It will demand consistent processes for appraisal, including feedback from patients and colleagues. As such, it is expected that the new system will, over time, help to raise the quality of the medical workforce, by supporting doctors in continually updating their professional skills to deliver a service to patients. However, the new processes will inevitably identify some doctors whose competence gives cause for concern and for whom, if they are to revalidate, some form of remediation will be needed.

The Department of Health asked the Remediation Steering Group to look at how well remediation of clinical competence and capability issues works now in the NHS in England. We were asked to consider whether there are options for improving the way this is managed and delivered, so that doctors can access the support they need when they need it and patient safety can be assured. The Group had a great deal of first hand experience of tackling performance issues. We were also able to draw on both existing materials and research, as well as a survey undertaken especially to support this work.

We found that whilst there was much good practice in managing clinical competence and capability concerns, it was still an area that many employers and contracting bodies found difficult to manage. Providing suitable remediation packages was also challenging and was often difficult and very expensive. Indeed, it appeared that ignoring a problem until it became a crisis, sometimes seemed to be the easiest solution.

The Group developed a set of principles that should be followed when tackling poor performance:

- Patient safety should be paramount;
- Concerns about a doctor's practice must be addressed early, systematically and proactively in all healthcare settings; and
- The appropriate competent authority must take action where a concern is raised.

We considered the factors that will support or undermine how concerns are identified and dealt with through remediation. We developed some options for the future system and for how the complex issues around funding might be taken forward. We have identified a set of practical actions that organisations can take to reduce or prevent the need for intensive remediation or crisis management. Ministers will wish to consider which of the options they wish to explore further.

I have had the privilege of chairing the Steering Group on Remediation. I believe that this report sets out a practical way for improving the current situation. I would like to thank the Steering Group for their time, effort and commitment to taking this subject forward. I am pleased to present this report, which sets out the results of its work.

Professor Hugo Mascie-Taylor Chair, Remediation Steering Group

Steering Group members

Hugo Mascie-Taylor (Chair)	NHS Confederation
Jane Adam	AoMRC (RCR)
Jo Anthony	RST
Iain Barclay	Medical Protection Society
Edwin Borman	BMA
Ailsa Donnelly	PPG RCGP
Mike Cheshire	North West SHA
Anthony Chuter	PPG RCGP
Blake Dobson	GMC
Jackie Hayden	North West Deanery and English Postgraduate Deans
Has Joshi	RCGP
Ann Macintyre	Guys and St Thomas's Hospital
Claire McLaughlan	NCAS
Laurence Mynors-Wallace	AoMRC(RCPsych)
Peter Old	NCAS
Mike Pringle	RCGP
Colin Pollock	Yorkshire SHA
Anna-Maria Rollin	AoMRC (RCoA)
Doug Russell	Tower Hamlets PCT
David Sowden	East Midlands Deanery and English Postgraduate Deans

Observers

Joyce Cairns	Northern Ireland Department of Health, Social Services and Public Safety
Sally Davies	PGMDE Wales
Iain Finlay	Scottish Government

Contents

Executive Summary

The topic of remediation is one of key interest to the medical profession. Although few doctors will have need to access a formal remediation programme during their career, for those that do their ability to get the help they need may well depend on where they currently work and the network of local support their medical director is able to access. The introduction of revalidation for doctors will provide a more structured on-going assessment of clinical performance based on doctors demonstrating they are meeting the principles and values set out in Good Medical Practice framework. This work has highlighted the need to ensure the approach to remediation is more structured and consistent.

The Department of Health sent out a questionnaire to every Trust and PCT in England in December 2009 to understand the scale of the problem and the approaches currently taken to tackling performance concerns. The survey revealed a wide range in how concerns are investigated and remediation delivered. There was also a wide variation in the scale of the problem being managed in each organisation. Respondents also put forward many ideas on how tackling performance concerns could be improved, including many things that NHS organisations could do locally.

In January 2010, the Department of Health established a Steering Group to consider remediation, focussing on managing competence and capability issues. Many members of the Group had considerable personal experience of tackling clinical competence and capability problems and were able to draw upon this experience as well as the Department of Health survey and other recent work in developing their ideas.

In looking at how remediation could be better managed, the Group made six broad recommendations.

1 **performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible;**

2 **local processes need to be strengthened so as to avoid performance problems wherever possible, and to reduce their severity at the point of identification;**

3 **the capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required;**

4 **a single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service;**

5 **the medical Royal Colleges to produce guidance and provide assessment and specialist input into remediation programmes;**

6 **postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are addressed.**

Associated with each of these recommendations are a number of points describing what needs to change. Some of these points are in fact already requirements for those NHS organisations employing doctors, but it would appear they are not always routinely happening. For example, there is already a requirement for the medical director and the human resources director to work in partnership when they are determining the course of action to be taken where there are concerns about a doctor's performance, but the Group noted that there were many instances where this did not happen, especially in the early stages, leading to more complexity and cost in resolving performance problems.

Prevention, as far as possible, was seen by the Group to be as important as improving the way that performance problems are remediated. There is much that organisations can do locally to minimise the occurrence of poor performance and the need for remediation. Good processes that deal with concerns as they arise and systems that support doctors to address their problems have been shown to minimise the need for exclusion and a full remediation programme.

Whilst not in the original terms of reference, the Group heard clear messages from employing and Doctors' organisations that funding for remediation should be more equitable. Currently, most doctors in secondary care have their remediation funded by their trust. Doctors in primary care often make a financial contribution to their own remediation. The Group recognised that there was unlikely to be any new money for remediation and developed a number of ideas for how more equity might be achieved. These will need to be investigated further to determine their feasibility and practicality.

Chapter 1 Introduction

1.1 Patients rightly expect their doctors to remain up to date and fit to practise throughout their career, and capable of undertaking the job they are currently doing. The great majority of doctors expect no less of themselves. However, despite a long and intensive training, there are occasions when some doctors develop clinical competence and capability problems and are no longer able to continue in independent practice. Getting doctors back to full and unsupported medical practice is the aim of remediation. However, whilst the ambition will be to get the doctor back to their previous role it must be recognised that this will not always be possible. Patient safety will always be paramount.

1.2 Representatives of the medical profession told the Department of Health that they felt the way remediation was currently being managed and dealt with across the NHS in England was variable. The need for a good and consistent approach to remediation is independent of the new regulatory process of revalidation that will be introduced by the GMC for all licensed doctors. However, improved clinical governance and the more robust annual appraisal processes which will underpin revalidation may well mean that, at least in the short-term, more doctors are identified who have a clinical competence and capability issue, and are in need of remediation.

1.3 In January 2010, the Department of Health set up the Remediation Steering Group to help develop some options for how remediation could be more effectively organised in the future. The Group consists of representatives from the medical royal colleges, postgraduate deaneries, employers, patient groups, defence organisations, the British Medical Association (BMA) and regulators, most of whom have extensive experience of dealing with performance issues. The terms of reference for the Group are set out in Annex 1.

1.4 Remediation is an issue that has been reviewed recently by a number of organisations including the Department of Health, National Clinical Assessment Service (NCAS), the Academy of Medical Royal Colleges and the Royal College of GPs.

1.5 The Department of Health published the Tackling Concerns Locally (TCL) clinical governance sub-group report[1] in March 2009. This set out 12 principles that should underpin the approach to remediation for health professionals. These are:

1. Remediation must ensure the safety of patients and the public while aiming to secure:
    - the well-being of the healthcare professional and the wider team;
    - the robust delivery of services based on agreed patient care pathways; and
    - consistent competence of the healthcare professional across scope of practice.
2. There should be lay and patient input into the quality assurance and delivery of remediation.
3. Primary Care Trusts (PCTs) and healthcare providers should maintain an available and accessible, quality assured process of remediation for all professional groups.
4. Decisions on remediation should be based on evidence using validated tools for assessment of performance, conduct and health.
5. Remediation should be personalised to the individual healthcare professionals and their learning style.
6. Remediation should be of high quality.

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096492

7. The performance of the professional during and following remediation should be monitored by quality assured methods.

8. The work environment for remedial placement should include adequate, quality assured supervision by a named individual.

9. There should be training and support for the whole clinical team working with the professional undergoing a remedial placement.

10. All those involved in the remediation process should uphold the NHS commitment to equality and recognition of diversity.

11. Remedial training and reskilling must be adequately resourced.

12. Healthcare organisations to define success criteria & learn from experience.

1.6 The Steering Group broadly agreed with these principles, which are set out in full in Annex 2. However, it was clear to the Group that these principles have not been widely adopted by the NHS in England and that in practice some of them would be difficult and expensive to achieve.

1.7 Some research was undertaken to support the TCL work but it was limited in scope, geographical coverage and sample size. However, it did highlight some inconsistencies in the way remediation was delivered. To better inform future policy options it was decided more detailed information was needed from NHS organisations across the country. A new survey was designed, tested and circulated in December 2009. This provided a more comprehensive picture of what was happening across England.

1.8 The findings from the Department of Health remediation survey, and the TCL report along with other recent work on remediation, helped to inform the thinking of the Remediation Steering Group.

1.9 On 12 July 2010 the Government published its White Paper: 'Equity and Excellence: Liberating the NHS'. This set out how power would be devolved from Whitehall to patients and professionals.

1.10 As the quality of information made available to patients improves, it may be that clinical competence and capability issues amongst doctors are highlighted.

1.11 The Remediation Steering Group focussed on how clinical competence and capability issues for qualified doctors currently in clinical practice in England could be better managed. The Group was not required to look in detail at doctors in training, because there is already a process of remediation through the deaneries. The Group did not examine what could happen in the private sector or for doctors working in non-clinical areas (for example medical management, academia or the pharmaceutical companies). These aspects could be explored in the future, although the processes may well be very similar.

Chapter 2 Steering Group

2.1 The Remediation Steering Group was established in January 2010 to look at how remediation might be more effectively managed. The group had a broad membership including employers, human resource departments, deaneries, medical royal colleges, SHAs, PCTs, the BMA, the GMC, the Revalidation Support Team (RST), defence organisations, patient groups, and National Clinical Assessment Service (NCAS). Members of the Group were selected for their direct experience of dealing with doctors with performance difficulties and of instigating or managing remediation programmes. The Group's remit was confined to looking at the provision of remediation in England. The Welsh Assembly, Scottish Government and Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS) attended the meetings as observers.

2.2 A number of previous reports and research into remediation provided the background material that informed the discussions of the Group. A survey undertaken specifically to inform this work gave a picture of the current situation in England. This included the views of medical managers about how things might be improved. These are described in chapters 4 and 5.

2.3 The Group met on four occasions and worked in a variety of ways including formal presentations, facilitated discussion and small group brain-storming. An early task was to map out the current process and personnel involved from first raising a concern about a doctor and the many entry and exit points in remediation (see Annex 3). The Group noted that although there were very many ways that clinical competence and capability concerns might be raised, the most usual ways were through peers raising concerns and Serious Untoward Incidents (SUI). In thinking about options for the way forward in managing the remediation process, the Group were mindful of the financial climate and the fact

there were unlikely to be new resources. The conclusions and recommendations from the Group are set out in chapters 7 and 8.

Chapter 3 Remediation

3.1 What is remediation? Dictionary definitions vary, but at its simplest it is an action taken to remedy a situation. In relation to healthcare professionals, the Tackling Concerns Locally report published the following definitions, which the Steering Group took as its starting point:

Remediation: the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.

Reskilling: provision of training and education to address identified lack of knowledge, skills and application so that the practitioner can demonstrate their competence in those specific areas.

Supervised remediation programme: a formal programme of remediation activities, usually including both reskilling and supervised clinical placement, with specific learning objectives and outcomes agreed with the practitioner and monitored by an identified individual on behalf of the responsible healthcare organisation.

Rehabilitation: the supervised period and activities for restoring a practitioner to independent practice – by overcoming or accommodating physical or mental health problems.

3.2 The focus of the Group has been to review how clinical competence and capability issues are dealt with currently, how they could be in the future and how the remediation of doctors should be managed and options for funding. The Group recognised that clinical competence and capability problems may be the result of health or behavioural problems. Health issues should always be dealt with as a priority. Behavioural issues are primarily the responsibility of the employer and should normally be handled through the organisation's human resources and disciplinary procedures. Clarity about which process is being

deployed is necessary at the outset and senior human resource advice is required.

3.3 The Group acknowledged that the word remediation had negative connotations and looked to find an alternative word that might be used instead. This was not achieved largely because the problem is more related to negativity about the actions and processes that arise from a need for remediation, rather than the word itself.

Chapter 4 Development of the current system

4.1 It is said that 2-3% of doctors at any one time may have some sort of clinical competence and capability issue, although there is only limited evidence to support this. The only detailed study into this was done in 1994 by Sir Liam Donaldson who looked at doctors in the North East of England[2]. This found that 6% of all medical staff were involved in some type of disciplinary problem over a five-year period and of these 40% arose largely from clinical competence and capability issues.

4.2 Concerns about the processes used to identify and tackle these doctors have been well documented. *"Supporting doctors protecting patients"*[3] was published by the Department of Health in 1999. It highlighted a set of weaknesses that were inherent in how performance issues were being addressed:

- major problems often surface as a serious incident when they have been known about in informal networks for years;
- over-reliance is placed on disciplinary solutions to problems late in the day, whilst mechanisms to produce earlier remedial and educational solutions are particularly weak. Often the human resource function is not involved until disciplinary proceedings are unavoidable;
- NHS trusts and health authorities are often deterred from taking action because the disciplinary processes are regarded as daunting and legalistic;
- there is no clarity at local level about the interface between GMC procedures and NHS procedures so that there is confusion about who does what and when;
- mechanisms to identify and help sick doctors are unsatisfactory;
- in the past, too many problem doctors have been moved on to become another employer's problem rather than being dealt with; and
- the timescales for dealing with serious problems can be very protracted and often last months or even years.

Source: Supporting doctors protecting patients 1999

[2] Doctors with a problem in the NHS workforce BMJ 94; 308:1277
[3] Supporting doctors, protecting patients DoH 1999

4.3 The report analysed the impacts of the existing processes for dealing with the poor performance of doctors:

- they do not provide proper protection for patients;
- they are not always fair to doctors;
- they are cumbersome and costly to operate; and
- they do not work in support of NHS organisations in their role of delivering high quality health care to the public.

Source: Supporting doctors protecting patients 1999

4.4 It also identified a set of criteria against which the success of any changes might be measured:

- reduction in numbers of patients experiencing harm or sub-optimal outcomes of care due to poor practitioner performance;
- doctors with competency, conduct or ill health problems recognised at a much earlier stage than at present;
- Doctors willing to report their concerns about colleagues;
- confidence of public and patients that the doctor who treats them is well trained, highly competent and up-to-date in their practice;
- patients not put at risk or denied a response to their concerns because the system is finding it too difficult to assess or decide how to resolve problems with a doctor's practice;
- the workings of the regulatory bodies fulfil explicit criteria, easily understood and publicised;
- widely accepted statements on standards of conduct, performance and ethics primarily aimed at the protection of patients;
- a strong effective partnership between the NHS and medical professional bodies to prevent, recognise and deal with poor clinical performance;
- protracted, expensive disputes with uncertainty about how to resolve serious problems a thing of the past; and
- benefits for doctors in the availability of well targeted continuing professional development and support.

Source: Supporting doctors protecting patients 1999

4.5 The report recommended setting up an Assessment and Support Service with a number of centres around England, run jointly by the NHS and the medical profession. This idea then evolved into the establishment of the National Clinical Assessment Authority (NCAA) as a Special Health Authority in 2001. This was

announced in "*Assuring the Quality of Medical Practice"* [4]. The NCAA became the National Clinical Assessment Service, NCAS, in April 2005. It is a legal requirement for NHS health-care providers to contact NCAS when they are considering excluding a doctor from work. NCAS also provides an advice and assessment service to the NHS about any doctor where there are performance concerns. This is currently free at the point of delivery. Further details of the way that NCAS works are set out in Annex 4.

4.6 Since the publication of *"Supporting doctors protecting patients"* a number of other important changes have been introduced that have affected the way that performance issues are identified and dealt with.

4.7 Annual appraisal became a requirement for all NHS doctors in England in 2002/2003. Whilst essentially developmental in nature, appraisal discussions can surface issues about areas of work where there are competency problems, and where action needs to be taken. Personal development plans should include actions to remedy any minor performance issues.

4.8 In 2005 "*Maintaining High Professional Standards in the Modern NHS"* [5] was published. This set out a framework to guide employers of doctors which 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 clinical competence and capability; and
- arrangements for handling concerns about a practitioners health.

It was developed and agreed 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.

[44] Assuring the Quality of Medical Practice DoH 2001

[5] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

4.9 *Maintaining High Professional Standards* is embedded into doctors' terms and conditions for those working in secondary care and for those employed by primary care trusts. These organisations are obliged to use the framework to develop their own policies, procedures and guidance for managing performance concerns and remediation. The Performers List Regulations 2004[6] set out the actions that a PCT must take when it is considering suspending or removing a contracted GP from its list whether for performance concerns or for other reasons.

4.10 In both primary and secondary care NCAS is a resource that the NHS can and does draw upon, although there are a number of other organisations that have also developed a role in remediation.

4.11 Although their main remit is doctors in training, postgraduate deaneries offer some support to registered GPs and primary care trusts through continuing professional development (CPD) programmes. A few deaneries also offer some level of support to doctors not in training but who are in difficulties. Some have confidential help-lines for doctors with health related problems. However, there is no formal basis for them doing so and no specific funding for supporting doctors not in training. Therefore, any remediation activity depends on the personal support of the Dean.

4.12 The medical Royal Colleges set standards and many colleges have assessor pools that carry out reviews of poorly performing teams. They provide advice to employers on standards and courses, but most do not engage directly in remediating individual doctors. However, the Royal College of Surgeons England and Royal College of Obstetricians and Gynaecologists do support employers in designing and implementing the clinical elements of further training

[6] http://www.legislation.gov.uk/uksi/2004/585/contents/made

and return to work programmes where this has been recommended for an individual doctor following a formal performance assessment.

4.13 Medical defence organisations represent individual doctors. They seek to ensure that a member who is facing some sort of proceedings in relation to their professional work is fairly treated and so support doctors in achieving a reasonable outcome. Where members are deemed to present a high level of risk the defence organisation itself may ask them to undertake specific training, which they will have to fund themselves. Some medical defence organisations offer educational courses, open to both members and non-members, particularly focussing on behavioural and communication issues.

4.14 The GMC focuses on fitness to practise. A doctor may be required by the GMC, through a fitness to practise process, to undertake a course of remediation as a condition of remaining on the register. The responsibility to ensure that the remediation happens rests with the doctor and they are re-assessed after any remediation as a pre-cursor to returning to full independent practice.

4.15 There are two aspects to the BMA's involvement in helping doctors where concerns have been raised:

- *Doctors for Doctors* provides confidential counselling for doctors who are facing difficulties, including GMC issues; and
- The BMA also offers a service to advise and support those doctors who have contractual difficulties.

4.16 The current strategic health authority structure can provide some support to medical directors who are dealing with doctors causing concerns.

Chapter 5 Is remediation working?

5.1 Despite the many changes that have taken place since 1999, concern was expressed to the Department by groups representing doctors, including the BMA, individual colleges and the Academy of Medical Royal Colleges, that the approach being taken to providing remediation was not consistent. The perception was that despite setting up NCAS, which assists organisations with assessments and remediation of the most severe cases, many of the underlying weaknesses appeared to be the same as they were in 1999. The success criteria that were identified in *Supporting doctors, protecting patients* as the requirements of a good approach to dealing with performance concerns had not thought to have been met. With revalidation about to be introduced, there is an urgent need for a process that is fair and equally accessible wherever a doctor is based.

5.2 There is a perception that low-level concerns may remain unaddressed for many years. This approach presents obvious risks to patient safety, and risks for the poorly performing clinicians who may not get the support they require until it becomes very difficult and expensive to remediate them. Even at the most severe end of the spectrum, where an organisation is considering excluding a doctor, there are perceived to be delays in the process..

5.3 Whilst there was much good practice, many organisations continue to struggle to recognise and deal with performance problems in a timely and effective manner and found difficulty in accessing appropriate remediation processes. There is a confused picture as to the services colleges and postgraduate deaneries provide. This confusion is thought to be extremely unhelpful, as is the difficulty in securing appropriate remedial placements.

5.4 The Department of Health England carried out a survey of NHS organisations in England between December 2009 to January 2010 to get a current picture of the

way in which all performance problems were managed and, if necessary remediated. The survey also attempted to assess the scale of the problem. A 50% response rate was achieved with a good coverage of all types of trust in most SHA areas. In total 75 primary care and community trusts, 93 acute trusts, and 30 mental health trusts responded. The respondent was usually the medical director or a senior medical manager.

5.5 With a 50% response rate, it was important to do some sort of quality assurance to check the general thrust of the response was representative of the total population of trusts and PCTs. The summary of the quantitative responses for each geographic area was returned to the relevant SHA for review. In all instances this review confirmed that the responses were in line with expectations. This enabled the total number of all doctors currently undergoing remediation in England to be estimated. In addition a large number of suggestions were made as to how existing processes should be improved. The survey is attached at Annex 5.

5.6 The responses confirmed a very varied picture across England as to how concerns were investigated and resolved. There was also variation in the use of different types of remediation processes and different sources of help.

5.7 Over 90% of organisations claimed that they had relevant policies and guidance in place. Over 90% of organisations were confident these were followed. This is in contrast to the situation described in 1999 in *Supporting doctors, protecting patients*, when only a few organisations had any such guidance.

5.8 The number of remediation cases with which any organisation was dealing, at the point the survey was returned, varied considerably from zero to more than 20.

Total number of current cases (at the time of the survey)

	PCT	Acute	MHT
Number:	260	212	27

In total respondents were dealing with 499 cases at the time of the survey. Extrapolating from the 50% response rate these figures suggest that there could be about 1,000 cases being dealt with at any one time in England, covering all types of remediation.

Number of concerns actively investigated over past 12 months

	PCT	Acute	MHT
Number:	753	552	97

Over the past year the respondents reported that 1402 doctors had been actively investigated. Again, extrapolating from this figure, it would suggest around 2,800 doctors have been investigated, representing 2% of all doctors working in the NHS in England.

5.9 Less than 12% of organisations had any specific funds for remedial activities, although nearly 90% of them said that they would make some sort of financial contribution to the remediation of doctors. In acute and mental health trusts it is uncommon for a doctor to be expected to invest financially in their own remediation. Conversely, nearly 50% of PCTs may ask a doctor to make a financial contribution and a third reported they sometimes expected doctors to meet the entire cost. This may reflect the contractual status of a GP as compared with the employee status of a doctor in a trust.

5.10 Only one PCT, three acute trusts, and one mental health trust routinely chose to bring in external support to carry out an initial investigation into a concern. Provider organisations gained support in different way, including NCAS, postgraduate deaneries, medical Royal Colleges and independent companies and wherever possible, internal resources. A range of remedial approaches were used, the most common being mentoring and supervised placements within

the Trust or PCT area. Less than 33% of PCTs and mental health trusts used placements in other trusts. Under 50% of trusts and PCTs used returners' schemes as part of a remediation package.

5.11 A question was asked about the activities that staff in each organisation were trained to undertake. Most organisations had people trained to investigate complaints and assess what action was required. Trained mentors were available in 87% of mental health trusts, 80% of acute trusts and 57% of PCTs. However, only around a third of PCTs and mental health trusts had people specifically trained to provide supervised placements. Only 59% of PCTs, 41% of acute trusts and 27% of mental health trusts had staff trained to assess whether remediation was complete. Since this is an employer responsibility this is a significant issue. Nearly every trust in secondary care involved human resources when there were performance concerns. However, in primary care 33% of PCTs did not involve human resources staff or expertise.

5.12 In addition to the quantitative questions, organisations were asked to contribute ideas about what aspects of the system needed to change to deliver a better way of managing concerns and remediation. They suggested a need for much more consistency in identifying and tackling poor performance. There also needed to be clarity about the roles and responsibilities of different organisations that were active in supporting remediation.

5.13 Organisations thought that much could be done locally to improve the capability to identify and tackle concerns. Recruitment processes were not thought to be as effective as they should be in identifying candidates who had had performance problems in the past, or in picking up problems with new doctors.

5.14 Respondents felt there were still cultural barriers in reporting poor performance. The proposals contained in the recent consultation on Whistleblowing[7] and

[7] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120349

proposed amendments to the NHS Constitution should strengthen the protection given by organisations to whistleblowers. It would also strengthen the expectation placed on staff to raise concerns.

5.15 Organisations identified a need for clear internal processes and local guidance. Better performance data and clinical governance systems should help to produce objective evidence to both highlight concerns and aid review during the investigation of concerns. Training was needed for those dealing directly with the investigation of concerns, human resources departments and medical directors.

5.16 Organisations felt that a single point of external expertise would be helpful, given the relative rarity of clinical capability and competence issues. It would not be possible for every healthcare organisation to become expert in this compex area. The survey suggested that this service needed to be able to access a network of accredited placement hospitals and GP practices to provide supervised remediation placements. More details from the qualitative responses are set out in Annex 6.

5.17 Some other organisations also commented on remediation processes. The Academy of Medical Royal Colleges and the Royal College of GPs were concerned about equity of access to remediation in the context of revalidation. They had set up working groups to look at how the system might be improved.

5.18 The Royal College of GPs completed a short piece of work in autumn 2009[8]. The college supported the four stages of remediation proposed by Tackling Concerns Locally:

- Identifying issues;
- Investigation;
- Deciding on action; and
- Remediation – re-skilling and rehabilitation

[8] http://www.rcgp.org.uk/_revalidation/revalidation_documents.aspx

They set out how each of these might work in a primary care context. The paper proposed that the local primary care organisation (PCO) and deanery should share the cost of remediation themselves and the PCO should meet any other costs. Although currently GPs often contribute to the cost of remediation, the RCGP believed that GPs should be funded to the same extent as hospital doctors. Currently the RCGP does not offer direct support to PCTs dealing with remediation cases, although they are considering providing a practice review service.

5.19 The Academy of Medical Royal Colleges, which represents both medical royal colleges and faculties, set up a working group to consider the potential interrelationship between revalidation and remediation in 2008-09[9]. The group recognised that performance concerns had been unlikely to emerge for the first time at appraisal, but said that appraisers needed to be made aware of any concerns and that these should form part of the appraisal discussion. The group endorsed the principles for return to work set out in NCAS's guidance document Back on Track[10] and the remediation principles set out in TCL. The group considered the direct role of colleges in the remediation of individuals would be limited. They felt there was a direct role for colleges in concerns relating to a team or department, but only an indirect advisory role in relation to individual cases on standards, courses and supervision.

5.20 The AoMRC group made four recommendations for further action on remediation:

1. The Departments of Health in the UK need to establish information about the existing provision of remediation;
2. The Department of Health in conjunction with NCAS should develop detailed guidance on remediation following the introduction of revalidation;

[9] http://www.aomrc.org.uk/introduction/news-a-publications.html
[10] http://www.ncas.npsa.nhs.uk/publications/

3. The Departments of Health in the UK need to explore and evaluate the potential impact of revalidation on remediation programmes; and
4. The provision of remediation should be monitored, maintained, and quality assured to a level where it continues to support appraisal and revalidation.

5.21 In addition to its report on remediation the AoMRC produced a set of scenarios based on real cases, where concerns had been raised about a doctor's practice, and how these might be resolved.

Chapter 6 What does poor performance currently cost the NHS?

6.1 The Department of Health survey did not ask respondents directly about how much they spent on remediation. This was because very few organisations have a budget line specifically for remediation, or have attempted to quantify the full costs. Data was gathered about costs through follow-up interviews with Trusts and PCTs and from information provided by NCAS and the Welsh Assembly Government. The costs associated with dealing with a doctor with performance concerns could be very significant. An initial investigation could cost up to £20,000 per doctor. A placement in another organisation could cost around £60,000 for six months, excluding salary and accommodation costs. Increasingly organisations hosting placements expect to be paid and in addition, there are locum costs to backfill the doctor undergoing remediation.

6.2 The largest type of direct cost arose when a doctor had to be excluded from work. In 2009, 77 doctors in the UK were suspended by the GMC, but during 2009/10 about 108 were excluded by their NHS employer, pending GMC fitness to practice proceedings[11]. Providing cover for excluded doctors is expensive. The cost of locum cover for such doctors could be up to £200k/doctor/year. This is in addition to the salary of the suspended doctor, which in primary care is often paid at 90% of the usual rate and at full cost in secondary care. Waiting for the GMC to reach a decision could push up costs significantly. The sooner problems are identified and successfully tackled the better – both in terms of reduced cost and successful outcome. Annex 7 sets out some indicative costs for remedial

[11] NCAS: Use of NHS exclusion and suspension from work amongst dentists and doctors - 2009/10 mid year report

interventions in primary care and has some case studies to illustrate the problems facing employers and contractors, and the costs involved in difficult cases.

The indirect costs of poor performance

6.4 Department of Health statistics show that about 500,000 patients a year are accidentally harmed in the NHS. The most common cause is patient accidents, such as falls, but there are around 140,000 incidents per year arising from treatments and procedures, or clinical assessment. Although there is no breakdown of why these are happening, some of these are caused by doctor error. 30,000 incidents lead to formal complaints and around 6,500 to litigation.

6.5 The NHS Litigation Authority (NHSLA) was set up as special health authority in 1995 with the principle task of administering schemes to help NHS bodies pool the costs of any loss of or damage to property and liabilities to third parties for loss, damage or injury arising out of the carrying out of their functions. All trusts and PCTs contribute to the NHSLA. In 2009/10 the NHSLA paid out Irrelevant information redacted by the USi in clinical negligence claims. During that year 6,652 new claims were lodged with the NHSLA. Whilst by no means all of these claims can be attributed to doctor error, poor clinical performance is inevitably a factor in some cases and one with a very high cost attached.

6.6 Re-admissions may be an indicator of when medical care has not been achieved first time. According to Dr Foster in 2008/09 the NHS spent over £1.5bn on people being readmitted within a month[12]. Reasons for this included being discharged too soon, or having an additional health problem that was not originally diagnosed. The costs of this can run into hundreds of thousands of pounds for an individual hospital, and in some hospitals readmissions amount to 10% of all admissions.

[12] Dr Foster Hospital Guide 2009

Chapter 7 Conclusions and recommendations from the Steering Group

7.1 The Group concluded that there were a number of key problems inherent in the current system:

- lack of consistency in how organisations tackle doctors who have performance issues;
- lack of clarity about where a personal development plan stops and a remediation process starts;
- lack of clarity as to who has responsibility for the remediation process;
- lack of capacity to deal with the remediation process;
- lack of clarity on what constitutes acceptable clinical competence and capability;
- lack of clarity about when the remediation process is complete and successful; and
- lack of clarity about when the doctor's clinical capability is not remediable.

7.2 In order to address these problems there are a number of actions that need to be taken which can be summarised in the following six recommendations:

1. **Performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible;**

2. **Local processes need to be strengthened to avoid performance problems whenever possible, and to reduce their severity at the point of identification;**

3. **The capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required;**

4. **A single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service;**

5. **The medical royal colleges should produce guidance and also provide assessment and specialist input into remediation programmes;**

6. **Postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are fully addressed.**

These recommendations are expanded in the following paragraphs.

Performance problems, including clinical competence and capability issues, should normally be managed locally wherever possible.

7.3 Employers of doctors, PCTs and, probably in future, Clinical Commissioning Groups are to be responsible for ensuring that annual appraisals take place and that a personal development plan is agreed. They should manage remediation locally whenever possible. Conduct issues should also be handled locally using the local human resources procedures. The new post of responsible officer will have a key role in managing the interface with the regulator.

7.4 Dealing with issues locally does not just relate to the employing or contracting healthcare organisation. Crucially, the individual doctor has a personal responsibility for their conduct, clinical competence and capability and to:

- ensure that they are working to Good Medical Practice;
- working to the relevant specialty framework;
- meet any employment related standards for their current role;
- be honest about when they feel that they might have clinical competence and capability problems and seek early help and support; and
- engage constructively with their employer or contracting body when problems are identified.

7.5 All initial investigations should be carried out by the employer, practice or contracting body:

- health matters should be referred to occupational health or the relevant medical service;
- behavioural matters must be dealt with by the employer;
- clinical competence and capability issues should be dealt with locally in the first instance;
- regulatory matters should be referred to the regulator;
- any criminal matters should be referred to the police;
- there should be a consistent approach to providing remediation, locally delivered as far as possible, with active involvement, where appropriate, from 'expert' organisations.

7.6 The collective NHS has two main responsibilities whether as an employer or contractor of healthcare services:

- responsibility for patient safety, which is pre-eminent; and
- responsibility to support clinicians in meeting their personal responsibility to remain up to date and fit to practise.

Local processes need to be strengthened so as to avoid performance problems whenever possible, and to reduce their severity at the point of identification.

7.7 The Group recognised a large continuum of clinical competence and capability issues, from minor concerns that may be resolved through the annual appraisal and personal development plan process, to issues that require a very comprehensive training package and external assistance.

7.8 Organisations should put in place the following to reduce the risk of performance problems arising and where they do, to identify them at early stage:

- strong medical leadership;
- strong human resource leadership;
- effective recruitment procedures and processes;
- robust annual appraisals and personal development planning;
- consideration should be given to six-monthly review in the first two years following appointment to a career grade;
- normal mentorship for the first two years for doctors newly recruited to career grade posts;
- effective induction processes in place that include organisational ethos (including responsibility to raise concerns about colleagues' practice) and how performance issues are managed;
- promotion of self-referral schemes.

7.9 Once a concern is raised, an organisation should:

- tackle concerns promptly, ensuring the primacy of patient safety;
- fully assess concerns so that appropriate action is taken, following the relevant process;
- fully involve both the human resources director and medical directors who should together lead the process;
- follow an appropriate competent investigation process, including investigation into whether there are organisational issues that need to be addressed;
- maintain good documentation and record keeping throughout the process;
- provide as much information as possible to patients about the processes that are undertaken to resolve concerns that they have raised, whilst respecting

the appropriate confidentiality of the employee, in order that the patient is not lost in the process of investigating and remediating concerns;

- ensure the medical director/responsible officer and the human resources director work together to oversee the processes[13], including reviewing whether there are organisational problems that also need to be addressed;
- make it clear to a doctor who requires remediation what they must achieve before they commit to a programme. This should include clear boundaries, the method to be used for remediation, how they will be able to demonstrate that they have been remediated, how and who will assess whether they have successfully competed the programme, and the proposed timescale;
- ensure that where a doctor causing concern has been recently appointed and promoted, the medical director / responsible officer will liaise with the relevant postgraduate dean to ensure there are no systemic failures in the deanery selection and assessment processes;
- ensure there is a clear exit strategy for any remediation case;
- ensure the remediation process remains as confidential as possible and practicable.
- The Group recognised that many positive initiatives have already been taken locally (e.g. the Wessex Insight project), to tackle clinical competence and capability problems. The approach taken in primary care across Wales gives certainty to GPs about what will happen if they are referred to NCAS and require remediation. This is described in Annex 8.

Capacity of staff within organisations to deal with performance concerns needs to be increased with access to necessary external expertise as required.

7.10 The Department of Health survey revealed that many organisations did not have staff trained to deal with all aspects of the process of remediation, from the initial investigation at the point that a concern is identified to the point of assessing

[13] Maintaining High Professional Standards 2005 already mandates such an approach

whether remediation had been successfully completed. To deliver remediation an organisation requires:

- capacity at medical director, human resource director and clinical directors level;
- a pool of competent external investigators available to it;
- the role of responsible officers and their support teams to be closely linked with employers and contractors.

A single organisation is required to advise and, when necessary, to co-ordinate the remediation process and case management so as to improve consistency across the service.

7.11 There should be a single organisation to manage the process of remediation where it is not possible for an employer to do so, either because of the employers lack of experience or more likely, the complexity or the difficulty. This may need to include managing the assessment, retraining and reassessment. It could also include clarifying the funding arrangements, obtaining placements and co-ordinating Royal College input. The organisation would also give advice to employers, contractors and practices, and work to clarify the appropriate roles of other organisations. Clarifying the roles of different organisations in England so there is a coherent framework for managing the remediation of doctors is key to this process.

7.12 No new public organisation should be created to manage remediation processes. The detailed shape and governance of the organisation needs to be defined.

7.13 NCAS currently carries out some of the functions of the managing organisation. At the moment NCAS's services are free at the point of delivery. However, as a result of the Arms Length Body Review it will be required to become self-funding within three years. It may be that other providers will emerge who are equally

placed to carry out the role. They will need to demonstrate the requisite expertise.

7.14 In dealing with cases that the employing or contracting organisation cannot resolve on its own, the managing organisation should:

- provide expert advice to local organisations to facilitate wherever possible, the issue to be resolved locally.
- develop a system for providing and accessing clinical remediation placements;
- source a range of providers that can carry out remediation to an assured standard;
- develop relevant relationships with colleges to provide specialist input;
- establish the mechanisms by which it can be confirmed or not that after a programme of remediation a doctor has met the standard that is expected of them, and can return to full practice; and
- advise on funding arrangements.

The medical royal colleges should produce guidance and provide assessment and specialist input into remediation programmes.

7.16 Few Royal Colleges currently provide full support to the remediation process. However, triggered by the revalidation process they are helpfully producing increasingly clear standards. This is of course in addition to their role in providing education and assessing clinical capability and competence issues through examinations.

7.17 To assure patient safety as well as to support their own members and fellows the Colleges all need to play a full supportive role in the remediation process (recognising that they are neither the regulator nor the employer/contractor).

7.18 The Colleges may also need to provide advice in supporting the remediation process.

7.19 There may be some issues that need to be resolved before all of the Colleges agree to take on this extended role. These include the handling of indemnity issues and the funding required to support the work. Some Colleges have made very considerable progress in addressing these issues and hopefully other Colleges can benefit from this expertise. The Academy of Medical Royal Colleges may have a useful facilitatory role in this regard.

Postgraduate deaneries and all those involved in training and assessment need to assure their assessment processes so that any problems arising during training are addressed.

7.20 One of the themes that recurred in the evidence reviewed was that some trainees have successfully completed their training placements despite there being unresolved performance problem involving clinical competence and capability. Clearly any problems arising during training need to be fully resolved prior to accreditation.

7.21 Postgraduate deans have been designated as the responsible officers for doctors in training. As such, they will need to have good exchanges of information with the responsible officer in the organisations where doctors in training are working and with those supervising trainees. In this way, any educational or professional/clinical performance concerns should be raised promptly and dealt with fully. As remediation or targeted training at an earlier stage improves there should be fewer problems later in a doctor's career.

7.22 Postgraduate deans and deaneries may be in a good position to assist in the sourcing of remedial placements for doctors not in training grades, particularly in primary care.

7.23 Postgraduate deans already supervise postgraduate training and oversee the remediation of doctors in training grades. In granting the CCT, they are providing an assurance that each doctor is clinically competent and capable.

7.24 Some deaneries offer advice about remediation for non-training grade doctors. This may, from time to time be helpful, but it is essential that any process should be well documented. It is particularly important that there is clear accountability for the advice offered and any decisions made about return to practise. Some Postgraduate Deans have been particularly helpful in assisting remediation processes, but they cannot act as the employer/contractor or the regulator.

Chapter 8 Funding Options

8.1 Although the funding of remediation falls outside of the Terms of Reference of the Group, it is an important issue that urgently needs to be resolved. In a time of constrained budgets, the case for funding any part of a doctor's remediation needs to be well made.

8.2 Medical training is expensive. Estimates of the total cost vary according to specialty, but a conservative estimate is £250,000 per doctor to reach the point of full registration, which for most doctors is followed by a period of specialist training. A very large sum of money has been invested in each doctor by the time they become a career grade doctor.

8.3 It is not just a question of cost. The time taken to qualify in a specialty is typically around 13 to 14 years after entry to medical school. We therefore have a highly trained workforce who cannot be easily replaced and a demand for doctors which historically has been hard to meet.

8.4 There are a number of reasons why employers have been prepared to invest in the remediation of doctors and will continue to do so in some way in the future:

- public money already invested;
- time and cost of producing an equivalent resource;
- workforce planning assumptions;
- impact of recent legislation, particularly consideration of what constitutes discrimination.

8.5 Decisions on funding need to be fair and equitable and the investment in remediation should be proportionate to the likely outcome. Remediation is about getting back to independent practice, but not necessarily in the same role.

8.6 In some parts of the country, where it is traditionally hard to recruit doctors, employers have an added incentive to fund remediation. However, whether it is appropriate for employers to meet all the costs of remediation, particularly where these are substantial is questionable. There is strong evidence that where doctors have made some sort of personal investment in remediation they are more motivated to follow through to a successful conclusion. In North America it is usual for doctors to pay for both their own assessment and any remediation. In Australia and New Zealand it is the regulator that funds assessment, but clinicians that fund remediation. More information is set out in Annex 10.

8.7 When the Steering Group considered the options for funding remediation, they did so using the assumption that there was unlikely to be any additional money in the system. It also felt that some approaches such as money being held back for remediation by SHAs or the future NHS Commissioning Board, or Monitor were unlikely to work. The Group recognises that there is a need to explore any options in much greater detail. Therefore, it has put forward this series of possibilities for consideration and further investigation.

POSSIBLE METHODS OF FUNDING

Doctor meets all or part of the costs of their own remediation

8.8 Doctors often fund part or all of their own CPD. It might be reasonable to think therefore that doctors should be expected to fund all or part of their own remediation. Not keeping up with CPD might be a factor in the need for remediation so it is not unreasonable to think that an equivalent contribution should be expected to fund any required remediation.

8.9 If this option were routinely used, there might need to be mechanisms to allow some doctors to borrow the money they would need to fund remediation. This could be through a loan scheme, but it might need to be underwritten by the

State because doctors in this situation might be deemed high risk through normal commercial approaches.

Employer funds remediation

8.10 As described earlier in this section, there are a number of good reasons why employers and PCTs currently fund all or part of remediation. However, an open cheque book can bring its own problems. For example, no one would want to see the UK becoming an attractive venue for poorly performing doctors from overseas coming to the UK to access the support that is not available in their own country.

Doctor joins an insurance scheme/extension of indemnity provided by a medical defence organisation

8.11 There are no products currently available, but potentially there could be assistance with the funding for remediation, provided either through an insurance policy or as a benefit of membership of a defence organisation. Medical defence organisations and insurers may deem some doctors just too high risk to cover. Already, the cost of an indemnity premium varies considerably depending on the type of specialty that is practised. Currently, doctors employed in the NHS do not have to meet the costs of indemnity cover. Employers effectively do this, although the indemnity cover only applies for negligence. There might be potential for the employer and the employee to jointly pay into some form of pool, which might be insurance backed. However, this is likely to be resisted by both employer and employee, given the number of employees who might incur significant costs would probably be small and any insurance backed product could well have a prohibitively high premium.

Linking remediation to clinical negligence schemes

8.12 An option that could be explored is making a linkage between remediation and between the costs of remediation and the schemes run by the NHS Litigation Authority. The payments made to the Litigation Authority vary with the risk profile

of each organisation. There may be an opportunity to encourage robust organisation proceses (e.g. recruitment, induction, clinical governance, dealing with complaints etc) by a sliding scale of fees.

Mutuals or subscription clubs

8.13 Mutuals could provide a way of funding and providing remediation in a cost effective way. Groups of organisations would enter into reciprocal arrangements with each other. These arrangements could be in terms of putting money into a pool, based on the number of doctors employed, or providing resources in kind (eg example training placements). A variant on this would be to set up a club on a subscription basis. Being a member of the club could gain you some sort of quality mark and could help to reduce your NHSLA CNST premiums. It would also gain you access to support from the managing organisation and appropriate college and deanery input. Such an approach might have attractions for the private sector too.

Contribution of the private sector

8.14 Whilst the Group did not look at the private sector in terms of access to remediation, the Group noted that currently the private sector does not make any contribution to the remediation of any doctors that worked for them who also worked in the NHS. This was something that the Group thought needed to change as the private providers were benefitting from the investment of the NHS.

8.15 It is for Department of Health to consider which of these options it wishes to explore further.

Chapter 9 Other considerations

9.1 The new role of responsible officer came into force on 1 January 2011. All designated organisations employing doctors, including all NHS and private healthcare providers, now have to appoint a responsible officer. The responsible officer will be accountable for managing the revalidation process when it is introduced. During 2011, the responsible officer will ensure that their organisation's clinical governance and appraisal systems are sufficiently robust to support revalidation and that there are clear processes in place for dealing with performance concerns. The designated organisations must provide responsible officers with appropriate support to carry out their functions.

9.2 Although most responsible officers are likely to be existing medical directors, a specific training package has been developed to help prepare responsible officers for carrying out their functions. This will be delivered from early 2011. It will provide an opportunity to help embed some of the actions proposed by the Group for improving local systems for managing the remediation of poorly performing doctors. In addition, all medical managers need training for their role as managers of other doctors. This includes training in the associated human resources and performance frameworks in operation in their organisation and in particular in regulatory and employment matters.

9.3 There will be occasions when, despite all best endeavours, it will be necessary to conclude that a trainee or a qualified doctor should no longer practise and that remediation cannot be achieved. The Steering Group believes that there needs to be more work with the GMC to agree how to improve the management of these situations.

Annex 1

Terms of reference for the Remediation Steering Group

1 To review and confirm the principles of good practice on remediation set out in the report of the Clinical Governance sub-group of Tackling Concerns Locally.

2 To review the research on the current approach to the provision of remediation for doctors in England and identify whether there is other information that needs to be collected.

3 To review evidence on the cost-benefit and value for money of early remedial interventions, at both the organisational, patient and individual doctor level.

4 To assess the demand for remediation including any potential impacts deriving from the processes underpinning revalidation, such as improved clinical governance and strengthened medical appraisal, and look at the potential cost and resources impacts.

5 To make recommendations on the models and structures for delivering remedial services in England.

6 To confirm that additional operational guidance is necessary for healthcare providers about how to identify the need for and ensure access to remediation for doctors, and to help develop the specification for commissioning the guidance

7 In taking forward its work, the Group will bear in mind the definition of remediation set out in *Tackling Concerns Locally*: “the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.”

Annex 2

Recommendations for the Tackling Concerns Locally Report

1. Remediation must ensure **the safety of patients and the public** while aiming to secure:
   - the **well being of the healthcare professional and the wider team**;
   - the **robust delivery of services** based on agreed patient care pathways; and
   - **consistent competence of the healthcare professional** across the entire scope of their practice.

2. There should be **lay and patient input into the quality assurance and delivery of remediation**. This could for instance involve a "lay champion" of healthcare professional performance at the level of the trust board. In addition, patients under the care of a professional undergoing remediation should be informed.

3. Primary Care Trusts (PCTs) and healthcare providers should maintain an **available and accessible, quality assured process of remediation for all professional groups** as an integral part of their local performance processes. A senior executive team member of the organisation should be responsible for the implementation and quality assurance of these processes and there should be regular reports to the board on the progress of individual practitioners. Self-referral by practitioners should be encouraged.

4. Decisions on remediation should be based on evidence using **validated tools for assessment of performance, conduct and health**. This would include assessment of behaviour at work, functioning in the clinical team, clinical competence, feedback from patients, assessment of the work and organisational environment, and any underlying health issues.

5. Remediation should be **personalised to the individual healthcare professionals and their learning style**, with explicit goals and timescales that are proportionate to the risks to patient safety. The possible need for a clinical placement away from the normal place of work should be considered. Resource needs, and the relative contribution of the healthcare organisation and the professional for funding, should be agreed out the outset.

6. **Remediation should be of high quality.** All involved in providing remediation should be competent in relation to the process as a whole and expert in their own field. There should be clear, accurate and comprehensive documentation of all processes and meetings. Processes should respect confidentiality both of patients and of the professional.

7. The performance of the professional during and following remediation should be **monitored by quality assured methods**, focussing on the attainment of

planned goals. A designated individual should be appointed by the healthcare organisation to oversee and support the professional, both during remediation and during the transition back to unsupervised practice at the end of the remediation process. The responsible person should regularly review whether the plan still adequately protects patient safety or whether other action (eg referral to the national regulator) is necessary.

8. The **work environment for remedial placement should include adequate, quality assured supervision by a named individual.** The environment should reinforce the values of patient centred care. The relative responsibilities of the placement supervisor and of the individual responsible for the general oversight of the practitioner (see principle 7) should be clearly specified, including an agreed system for reporting any concerns arising out of the placement.

9. There should be **training and support for the whole clinical team working with the professional undergoing a remedial placement**, while maintaining confidentiality over discussions between the professional and those responsible for oversight of the process.

10. All those involved in the remediation process should **uphold the NHS commitment to equality and recognition of diversity**.

11. **Remedial training and reskilling must be adequately and appropriately resourced**. Healthcare boards must have a senior member responsible for the resourcing and operation of performance procedures who can make the case for investment in remediation, including sufficient capacity for clinical placements. This will involve effective partnership working with postgraduate deaneries/higher education institutions approved by the relevant regulatory bodies, and with other local healthcare organisations.

12. Healthcare organisations should **define success criteria and learn from experience.**

Annex 3

Remediation journey

IN

1 Entry

i Triggers

a. Monitoring clinical governance and audit data (and other relevant data)
b. Police
c. OH/GP (thresholds issues)
d. Complaints etc
e. Incidents
f. Whistleblowing
g. Peer review
h. SUIs/SEA
i. Revalidation/appraisal

ii Referrers

a. Self-referral
b. Colleagues
c. Friends and family
d. Employers
e. PCTs
f. ROs/MDs
g. Medical examiner
h. GMC
i. Deanery system/ARCP
j. Pharmacists/dispensers
k. Counsellors
l. Coroner's reports/Rule 43 letters
m. Child protection services
n. Social care cases
o. Media
p. Undertakers
q. Schools
r. PALs

EXIT

2 Scope the problem (most difficult problem)

a. Context review
    i. personal/non-personal
    ii. Team environment/individual
b. Identify manager

EXIT

3 Diagnostic process based on the medical model

a. History
   i. Personal
   ii. Team environment

b. Investigation
   i. Health/clinical competence and capability/conduct?
   ii. Is this person equipped for the job or not?
      1. OH (including cognitive assessment)
      2. Psychometric/behavioural issues
      3. Clinical performance
      4. MSF

c. Diagnosis and prescribing

EXIT

4 Intervention (or not)

EXIT

5 Interventions (not necessarily linear)

Types of intervention

- Advice
- Education and training – including re-skilling
- Coaching – behavioural change
- Mentoring
- Supervision
- Placement
- Work based assessment/learning assessment
- Team based approaches (in isolation or with others)
- Return from ill health

Dependencies (policy environment a key factor):

- Resources
  - Capacity in all its constructs
  - Finance
  - Engagement of doctor
  - Insight of doctor
- Other identified factors (non personal)
- Institutional culture]
- Willingness to retrain doctor
- Need for 3-way contract between doctor/employer/provider

EXIT

6 Post intervention review

Needs to be an external review

Actions

- Post-intervention analysis of accumulated evidence (self-assessment included)
- Decision-making – not just either/or
- Doctor to collect evidence of progress
- Ongoing review of progress

Conclusions

- Final outcomes (several possible)
    - Back to same job
    - Back to adjusted job (new employer/role)
    - New job
    - GMC (involuntary out – at moment no honourable voluntary out)
    - Voluntary out

[Dependencies similar to interventions]

EXIT (possible re-entry)

Annex 4

National Clinical Assessment Service (NCAS)

NCAS was established specifically to help resolve concerns about a practitioner's performance for which organisations needed external support. It offers advice, specialist interventions and shared learning. In terms of direct support for individual practitioners NCAS receives around 900 referrals a year about doctors, dentists, and pharmacists. The majority of referrals are about doctors. With around 150,000 doctors and 30,000 dentists working in the UK, each year the performance of about one doctor in 190 causes enough concern to result in an NCAS referral. For dentists the one-year referral rate is about one in 290. (Pharmacists referrals are a new work strand and therefore it is too early to comment on the referral rate.) These figures have not changed significantly since NCAS was set up. About 1 referral in 17 leads to a formal NCAS assessment being undertaken.

The assessment process is an intensive examination of a doctor's practice. The validity and reliability of an NCAS assessment depend on sampling across a practioner's practice using a wide range of instruments including:

- Occupational health assessment
- Behavioural assessment
- Review of information provided by the referring body and practitioner
- Records review
- Case based assessment
- Direct observation of practice
- Interview with the practitioner
- Feedback from colleagues and patients
- Review of the working environment
- Simulations (if necessary)

In addition to providing direct support to organisations, NCAS publishes a range of practical publications to help organisations deal with performance concerns effectively. Among these, Back on Track[14] 2006 addresses the retoration of practioners to safe practice and sets out seven guiding principles for employers in formulating their return

[14] Back on Track NCAS 2006

to work programmes. NCAS also undertakes an extensive programme of education and training for the NHS.

Annex 5

The Department of Health would like your help in providing a full picture of how Trusts and PCTs are currently responding to the need for remediation measures when there are concerns raised about a doctor.

For the purposes of this questionnaire, "concerns" means concerns about a doctor's conduct, performance or health related issues. These "concerns" may come to light in a number of ways, for example raised by the doctor, raised by another healthcare professional, resulting from analysis of clinical information, or raised by patients or their relatives.

Remediation was defined by the 'Tackling Concerns Locally' Programme[15] as the overall process agreed with a practitioner to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.

The information you provide will help us to build a baseline picture of current remediation provision across England and what steps should be taken to ensure that all doctors have access to appropriate support when the need arises.

Completing the questionnaire will take approximately 15 minutes. Thank you so much for taking the time to contribute to this important exercise.

The first two questions focus on your organisation

1. **My organization is a:**
   - **PCT**
   - **Acute Trust**
   - **Mental Health Trust**

2. **My organization employs**
   - **0-50 doctors**
   - **50-100 doctors**
   - **100- 300 doctor**
   - **Over 300 doctors**

The next set of statements focuses on how concerns are raised and dealt with initially

3. **The Trust/PCT has a clearly defined process for health care professionals to follow when raising concerns about a doctor in this organisation.**

[15] Tackling Concerns Locally: report of the Clinical Governance subgroup, DH, March 2009.

- Yes
- No

4. **The Trust/PCT has developed a policy that describes the immediate action to take when a concern is raised about a doctor.**
   - Yes
   - No

5. **The Trust/PCT has guidance in place that helps managers to start to deal with a range of concerns.**
   - Yes
   - No

6. **I am confident that the Trust/PCT policy guidelines are followed when responding to any concerns raised by health care professionals about a doctor.**
   - Strongly Agree
   - Agree
   - Slightly Agree
   - Cannot say
   - Slightly Disagree
   - Disagree
   - Strongly Disagree

7. **Do you think that the existing appraisal systems for doctors within this Trust/PCT are sensitive enough to provide early identification of any performance, conduct or health issues?**
   - Yes
   - No

8. **Staff recruitment and selection procedures reliably identify any conduct, performance issues of doctors seeking employment within this Trust/PCT.**
   - Strongly Agree
   - Agree
   - Slightly Agree
   - Cannot say
   - Slightly Disagree
   - Disagree
   - Strongly Disagree

9. **The Trust takes swift action after a concern is raised about a doctor, if a risk is identified.**
   - Strongly Agree
   - Agree

- Slightly Agree
- Cannot say
- Slightly Disagree
- Disagree
- Strongly Disagree

The next set of questions looks at how the concern is currently dealt with

10. How does the Trust/PCT carry out an initial investigation following concerns bring raised about a doctor?
- Internal resources
- Seeks external support from another specialist organisation

11. Following an initial investigation, and where further action is required, how does the Trust/PCT go about assessing what action is required?
- Internal resources, including HR
- NCAS
- Deanery
- Royal College
- Commission other external provider

12. Where a programme of remediation is identified as being necessary for a doctor, who provides this programme for your Trust/PCT?
- Internal resources
- Deanery commissioned programme
- Other external provider

13. What kind of remediation activities do you currently use in your Trust/PCT?
- Mentoring
- Returners induction schemes
- Supervised placements within your Trust/PCT
- Supervised placements in another Trust/PCT
- Deanery based schemes
- Other educational courses
- Healthcare support

14. How many remediation cases are you currently dealing with?

15. What future plans do you have for remedial services in your Trust/PCT?

Thinking about the funding of remediation in your organisation.

16. Do you have a dedicated budget for remedial activities in your Trust/PCT?

- Yes
- No

17. How are funds provided for the remediation of the doctor?

- Funds are found from within the Trust/PCT
- The Deanery pays for the remediation
- The doctor makes a contribution towards the remediation costs
- The doctor pays for their own remediation

Thinking about those within your organisation who are having to deal with concerns and remediation

18. Are people within your Trust/PCT trained to undertake:

• Investigation of complaints	Yes	No
• Assessing what action needs to be undertaken	Yes	No
• Provision of supervised placements	Yes	No
• Mentoring	Yes	No
• Assessing completion of remediation	Yes	No

19. Is the HUMAN RESOURCES DEPARTMENT department actively involved in the process when a concern is raised about a doctor working in the Trust/PCT.

- Yes
- No

20. Is Occupational Health is actively involved in the process when a concern is raised about a health care professional working in this Trust.

- Yes
- No

We would like your opinions about important developments

21. In your opinion, what are the two most important developments that would improve the processes and outcomes for raising conduct, performance or health concerns about doctors in your Trust/PCT?

Enter your text in the space provided:

22. **In your opinion, what are the two most important developments that would improve the Trust's processes for dealing with the remediation of doctors working in your Trust/PCT?**

    Enter your text in the space provided:

23. **How many concerns have been actively investigated in your Trust over the past 12 months?**

24. **If you have any further comments about the issues in this questionnaire, or any issues that you believe have not been addressed, please outline your comments in the box below:**

    Enter your text in the space provided::

Name:

Organisation:

Thank you so much for taking the time to complete this questionnaire

Annex 6

Qualitative questionnaire ideas

Those that responded to the survey thought that there was a lot that they could do to improve patient safety and to improve their own systems by putting in place mechanisms to help identify problems early:

- improved human resources department processes, particularly at the primary care level;
- better documentation of concerns as they arise until their resolution;
- ensure that consultants were clear about their responsibilities as line managers;
- existing recruitment processes were highlighted by many organisations as inadequate in flagging up performance problems. Ideas to address this included:
  - asking for three previous appraisal summaries
  - psychological profiling of candidates
  - compulsory induction process
  - assessed probationary period;
- address cultural problems in raising concerns:
  - make it clear that all staff have a duty to raise a concern
  - protection for whistleblowers
  - organisations to have processes in place to ensure that concerns raised are taken seriously, and not dismissed because they come from more junior staff or non-medical staff; and
- try to de-stigmatise remediation:
  - reposition it by recognising that there will be times throughout most people's career when they will have a need to improve and update their skills
  - support and promote self-referral.