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.

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: Hutchison, Ruth
Sent: 13 January 2012 12:55
To: Kilgallen, Anne; Roberts, Margot; 'Barkley, Mervyn'; O'Carolan, Donncha; Reid, Simon
Cc: Lorraine.Beck[redacted]; Dardis, Pauline; 'Davey, Noreen'; andrea.armstrong[redacted]; Garrett, Elizabeth; charlie.martyn[redacted]; Alison McMaster (PA)
Subject: DHSSPS - Revision of MHPS; Focus Group
Attachments: CiC_MPHS Focus Group Availability.DOCX

Importance: High
Sensitivity: Confidential

Dear Colleagues

Jane has asked me to set up a further meeting of the above group as soon as is convenient.

Perhaps you could advise of availability as per attached table.

Thanks

Regards
Ruth

Ruth Hutchison
Programme Support Officer
Confidence in Care Programme
Room C3.20, Castle Buildings
Belfast BT4 3SQ

Tel: [redacted]
Email: [redacted]

Roberts, Naomi

From: Lindsay, Jane
Sent: 17 January 2012 09:39
To: Colville, Victoria
Cc: Anderson, Gail; Woods, Paddy
Subject: RE: MAintaining High Professional Standards/Probationary Periods

Victoria

MHPS is primarily intend to outline the process for doctors and dentists when a concern has been identified. While the importance of robust employment processes may be referenced in the framework (including recruitment and selection) this will not be discussed in any detail given the existing policies in place for this in organisations (or should be in place,assume from your email this may not be the case) .

Happy to discuss further and review your paper when complete if that would be helpful.

Jane

Jane Lindsay
Programme 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

From: Colville, Victoria
Sent: 16 January 2012 15:53
To: Lindsay, Jane
Cc: Anderson, Gail
Subject: MAintaining High Professional Standards/Probationary Periods

Hi Jane

I am drafting a paper which relates to probationary periods (or lack of) in relation to medical staff.

It has been suggested by some Medical HR personnel in Trusts that the Maintaining High Professional Standards framework may currently or will in the future take account of probationary periods.

Are you able to comment further on this?

Any help would be appreciated

Victoria

Victoria Colville
HRD Medical
Room D1
Castle Buildings
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Roberts, Naomi

From: Colville, Victoria
Sent: 17 January 2012 11:35
To: Lindsay, Jane
Cc: Anderson, Gail; Woods, Paddy
Subject: RE: MAintaining High Professional Standards/Probationary Periods

Thanks Jane

Victoria

From: Lindsay, Jane
Sent: 17 January 2012 09:39
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Jane Lindsay
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Victoria Colville
HRD Medical
Room D1
Castle Buildings
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Roberts, Naomi

From: Lindsay, Jane
Sent: 25 January 2012 12:50
To: Kilgallen, Anne; mervyn.barkley Personal Information redacted by the USI Roberts, Margot
Cc: Woods, Paddy; O'Carolan, Donncha
Subject: Revision of Maintaining High Professional Standards

Dear All,

Our next meeting to discuss the revision of MHPS is scheduled for Wednesday 8th February at 11am.

I would be grateful if you could forward any comments on the current draft as discussed at our last meeting as I would hope to incorporate these into the draft framework for consideration at this meeting.

Many thanks.

Jane

Jane Lindsay
Programme Manager-Confidence in Care
DHSSPS,
C3.20,Castle Buildings
Stormont Estate
Belfast BT4 3SQ
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Roberts, Naomi

From: Lindsay, Jane
Sent: 27 January 2012 09:43
To: Reid, Simon
Cc: O'Carolan, Donncha
Subject: RE: Revision of Maintaining High Professional Standards

Simon

Please find attached the latest revision of Maintaining High Professional Standards as per emails below.

Best Wishes

Jane

Jane Lindsay
Programme Manager-Confidence in Care
DHSSPS,
C3.20,Castle Buildings
Stormont Estate
Belfast BT4 3SQ
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Revision of MHPS (v4) with cha...


Revision of MHPS (v4) with cha...

From: O'Carolan, Donncha
Sent: 25 January 2012 16:46
To: Lindsay, Jane
Cc: Reid, Simon
Subject: RE: Revision of Maintaining High Professional Standards

Jane,

Simon Reid can attend this meeting on behalf of dental branch. Would you e-mail Simon the latest draft and copy me in. I know you probably have already sent it on but have quite a back log of e-mails at present.

Thanks,

Donncha

From: Lindsay, Jane
Sent: 25 January 2012 12:50
To: Kilgallen, Anne; mervyn.barkley Personal Information redacted by the USI ; Roberts, Margot
Cc: Woods, Paddy; O'Carolan, Donncha
Subject: Revision of Maintaining High Professional Standards

Dear All,

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DHSSPS,
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Stormont Estate
Belfast BT4 3SQ
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Roberts, Naomi

From: Roberts, Margot
Sent: 27 January 2012 12:40
To: Lindsay, Jane; Kilgallen, Anne; mervyn.barkley [redacted] Reid, Simon
Cc: O'Carolan, Donncha; Woods, Paddy
Subject: RE: Maintaining High Professional Standards

Jane

I've also attached NIMDTA's document which is currently under revision.

Policy re doctors in difficult...

Margot

Margot Roberts
Administrative Director
Northern Ireland Medical and Dental Training Agency
Beechill House
42 Beechill Road
Belfast BT8 7RL

Tel: [redacted]
www.nimdta.gov.uk
[redacted]

From: Lindsay, Jane
Sent: 27 January 2012 10:01
To: Roberts, Margot; Kilgallen, Anne; mervyn.barkle [redacted] Reid, Simon
Cc: O'Carolan, Donncha; Woods, Paddy
Subject: Maintaining High Professional Standards

Colleagues,

At the last meeting of our MHPS working group we discussed the development of a section within the framework that specifically outlined managing concerns in relation to Trainees (see attached meeting note, point 3).

The link below will take you to an operational framework developed by NES Scotland that may help inform our thinking ahead of the next meeting on 8th February.
http://www.psychiatryspace.co.uk/newsites/school/documents/TTT/031108_Operational_Framework%20(2).pdf

Best Wishes

Jane
<< File: Revision of MHPS meeting of Working Group 181111.DOC >>

Northern Ireland
mdta
Medical & Dental Training Agency

GUIDANCE IN RELATION TO THE MANAGEMENT OF TRAINEES REQUIRING SUPPORT

1. Introduction

The policy has been written with a view to defining the procedures for dealing with trainees who may require additional support. The aims of the policy are to promote early identification of such trainees and provide a clear structure for identifying and addressing concerns. It is based upon the principle of acting fairly, supportively and confidentially when dealing with problem situations that arise and draws and should be read in conjunction with the publication from the Department of Health, Social Services and Public Safety on '*Maintaining High Professional Standards: A framework for the handling of concerns about doctors and dentists in the HSC'* This guidance provides the disciplinary framework for doctors and dentists in Health and Social Care and requires all HSC bodies to have procedures in place for handling serious concerns about an individual's conduct. The guidance covers restriction of practice and exclusion from work; conduct hearings and disciplinary matters and procedures for dealing with issues of capability.

It is the duty of all doctors/dentists to protect patients where it is believed that a doctor's/dentist's conduct, performance or ill health is a cause of concern. It is therefore the responsibility of the team with whom a trainee is working to highlight concerns before they become too severe and to enable the trainee to access the right help.

2. Roles and Responsibilities

A trainee has a contractual relationship with his or her employer and is subject to the policies established by the employing body. The employer has responsibility to ensure that employment issues, including performance, health and sickness issues and disciplinary matters are dealt with appropriately to facilitate the trainee's satisfactory performance.

The Northern Ireland Medical and Dental Training Agency (NIMDTA) has responsibility for commissioning education and training whilst the Trusts and other local education providers (LEPs) have responsibility for delivering education. LEPs have a responsibility to ensure that mechanisms are in place to support trainees and enable problems to be addressed at an early stage.

The educational supervisor is the most likely person to be involved initially when a trainee is in difficulty although the Director of Medical Education (DME), Clinical

Director, Medical Director, General Practice trainer, Dental trainer and NIMDTA may also need to be informed depending on the nature and seriousness of individual circumstances.

It is the responsibility of the LEP to investigate and manage concerns and NIMDTA must be informed of any significant problems. It is the responsibility of the Trust's DME to ensure that the Postgraduate Dean is made aware of any disciplinary action being taken against a trainee employed by the Trust. GP Trainers must inform the GP Director and Dental Trainers the Postgraduate Dental Dean about any significant concerns they have about a trainee. The flow charts attached at Appendix 1 provides guidance on the action an LEP should take when problems arise.

If through investigation it appears that the problem relates to the trainer or the training post then appropriate action will be taken by NIMDTA and where necessary a Deanery visit instigated.

If a trainee is excluded from the workplace or restrictions placed on a trainee's practice he/she will not normally be allocated to another LEP until a full investigation has taken place and the outcome known. This includes investigation by the police and by the General Medical Council (GMC)/General Dental Council (GDC) under its fitness to practice procedures.

3. Identifying trainees requiring support

All possible steps should be taken to identify and act on early signs and symptons of problems. The majority of these are behavioural but also include signs of clinical incompetence, for example poor record-keeping; poor clinical decision making and judgement, inappropriate referrals etc.

Successful remediation or support for trainees requires an understanding of the underlying problems. A checklist (Appendix 2) has been developed to help educational supervisors and others to diagnose and manage the early signs of a trainee who may be in difficulty.

Concerns about a trainee's conduct or capability may come to light through:

- an untoward incident
- a complaint or litigation
- appraisal
- assessment
- performance data or clinical outcomes
- clinical audit
- Concerns raised by colleagues

Clear evidence should be sought and concerns raised with the trainee at an early stage in order to obtain his or her perspective. The trainer should consult with colleagues to explore the nature and seriousness of the problem. As soon as it is clear that there is a problem with the trainee's conduct or performance action should be taken.

Managing potential risk to patients is the first priority and should be managed by the trainee and trainer/educational supervisor agreeing what the trainee can do safely and ensuring support and supervision from the whole clinical team to allow the trainee to practise safely in areas where he or she is underperforming. The clinical/service manager should be kept informed of the situation.

Once the underlying cause of the trainee's difficulties is identified a realistic learning plan should be provided that will motivate and engage the trainee. If it is not possible to deliver this in the trainee's current placement the trainee will need to be moved to a placement which will deliver the learning plan. The learning plan should be regularly reviewed throughout the course of its delivery to ensure that it continues to meet the trainee's needs. If the trainee continues to have difficulty, in spite of remedial action, advice should be sought from NIMDTA. Guidance in relation to remediation planning is available in Appendix 3.

As a general principle good communication should be maintained at every stage with NIMDTA being informed as appropriate and as early as possible. The educational processes need to work closely with the LEP's internal procedures and close communication between the appropriate individuals within NIMDTA and those responsible at LEP level is crucial.

4. The Problems

These can be divided into four main areas as follows:

- Personal conduct
- Professional conduct
- Competence and performance issues
- Health and sickness issues

Personal Conduct Issues

Examples include intoxication, drug abuse, falsification of records, theft, fraud, serious acts of insubordination, sexual, racial or sectarian harassment, unlawful discrimination or victimisation on the grounds of age or sexual orientation. The employing authority will take the lead under its disciplinary procedures and the DME or appropriate individual will inform the NIMDTA in writing at an early stage.

NIMDTA will not be involved in such a disciplinary panel but will need assurance of the following:

- The LEP will follow its agreed disciplinary procedure
- The trainee has been advised that they may be represented at any stage of the disciplinary procedure by the BMA/BDA, or work colleague
- Guidelines applicable to Northern Ireland are followed if a trainee is to be suspended
- Pastoral support is provided if required

On occasions it may be necessary for the LEP/Postgraduate Dean to advise the GMC/GDC of any action taken against a trainee.

Professional Conduct Issues

Examples include research misconduct, failure to obtain consent properly, prescribing issues, improper relationships with patients, improper certification issues (eg the signing of cremation forms, sickness certification) and breach of confidentiality. The LEP will take the lead under its disciplinary procedures and the DME or appropriate individual will inform NIMDTA in writing at an early stage. An agent of NIMDTA eg Head of School, GP Director, Programme Director or Dental Adviser will provide input into such a disciplinary process. Any decision to involve the GMC/GDC will be taken jointly by the LEP and NIMDTA. NIMDTA will need to be assured that:

- The LEP will follow an agreed disciplinary procedure
- The trainee has been advised that he/she may be represented in the process by a companion who may be:
    - another employee of the HSC body;
    - an official of the BMA, BDA or defence organisation;
    - work or professional colleague
- Guidelines applicable to Northern Ireland are followed if a trainee is to be suspended
- Pastoral support is provided if required

Competence and Performance Issues

Examples include a single serious mistake, poor results clinically (possibly found as a result of audit), poor communication skills, poor consultation skills and repeated failure to attend educational events.

Trainees with such problems will need to be referred by the DME or appropriate individual to NIMDTA. The LEP may need to take a lead in some of these problems if there has been a complaint from patients or relatives and the possibility of legal action.

In the event of an isolated serious mistake NIMDTA must be informed in writing and at each stage in any process that results from such a mistake. Pastoral support must be offered and the trainee advised to seek legal representation.

If the trainee's performance is consistently poor, despite educational measures such as remedial or targeted training, then it may be necessary to inform the GMC/GDC. Any decision taken will be agreed jointly by the LEP and NIMDTA.

It is accepted that LEPs have an over-riding duty to protect patients and staff, and exceptionally may need to invoke its policies and procedures to expedite a critical situation. NIMDTA should be kept informed of any such action.

Health and Sickness Issues

Every trainee must be encouraged to register with a local general medical practitioner and consult with their doctor in the first instance when ill.

'If you know that you have a serious condition that you could pass on to patients, or that your judgement or performance could be significantly affected by a condition or illness or its treatment, you must take and follow advice from a consultant in occupational medicine or other suitably qualified colleague on whether and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients'.

Ill health and sickness absence should be managed through the LEP's sickness absence policies. Where sickness absence gives cause for concern the trainee should be referred to the Occupational Health service and information shared with appropriate individuals on a need to know basis. NIMDTA should also be informed in writing of such cases and where the trainee's fitness to practise is called into question the referral should be made to the GMC or GDC as appropriate. Advice from either body may be sought in advance of referral.

Periods of grace due to sickness absence before training may be affected are as follows:

- Foundation 1 doctor – 4 weeks in the year
- Foundation 2 doctor – 4 weeks in the year
- GP Trainee – 2 weeks in each year of training
- Core Trainee – 4 weeks in each year of training
- Specialty Trainee – 3 months in the training programme before CCT date affected

5. Keeping Records

Documentation should commence as soon as a performance concern comes to light and copies given to the trainee. Whilst only a small minority of performance difficulties escalate into a disciplinary situation, records should nevertheless be kept from the earliest stage to help ensure continuity (e.g. a trainee who changes educational supervisor) and to avoid duplication of effort. Good documentation is an essential part of educational governance.

Should a problem with a trainee become more serious or repetitious, it may be advisable to seek guidance from the Human Resources Department who can advise on any further specific documentation.

Trainees need to have confidence that this documentation is intended to support and help them to address their difficulties rather than as a punitive or legalistic activity. Transparency is paramount to retain the trainee's trust and cooperation. The following will help to ensure openness as well as rigour:

- Educators should avoid recording and keeping information about discussions with doctors without their knowledge or consent.

- Records of conversations should be held confidentially, with the doctor's knowledge and consent, by the person who has conducted the assessment of the problem with the doctor in difficulty.
- The trainee should be given a copy of any documentation concerning his or her performance and encouraged to keep such copies in his or her portfolio for discussion at appraisals.
- Should the trainee move to a different job, or in the event that the problem escalates or others become involved, it may become necessary to pass the record to other parties.
- The transfer of information about a trainee's progress from post to post should become standard procedure including areas of concern.
- All documentation must comply with the requirements of the Data Protection Act and the Freedom of Information Act (FOIA).

6. Transfer of information to Future Education Providers

Where a trainee becomes ill during the training it is important that consistent support is provided which can be transferred across training placements. There should be one source of referral to Occupational Health for trainees appointed to training programmes/posts. Unless there are ethical barriers to doing so, information should be shared by NIMDTA to LEPs on a need to know basis.

In the interests of patient safety it may be necessary for NIMDTA to transfer personal information to other health and social care organisations or statutory bodies, in accordance with the principles and conditions set out in schedules 1, 2 and 3 of the Data Protection Act 1998.

The educational supervisor/trainer in the next placement must be informed of problems arising in the previous placement to ensure that any remedial action that has been taken continues and assessment of successful progress is made.

In instances where disciplinary issues or serious conduct or competence issues are involved a written statement must be given to NIMDTA to pass on to the new LEP, on a need to know basis, and with the knowledge of the trainee concerned. The trainee will have the right to see such a statement and challenge its accuracy, but not to prevent it being transferred to the new employing authority. Information should be accurately recorded with a clear account of the issue, the action taken and the date when any disciplinary action is considered to be spent.

Information will be transferred by the Postgraduate Dean to the Medical Director of the new LEP where a trainee is:

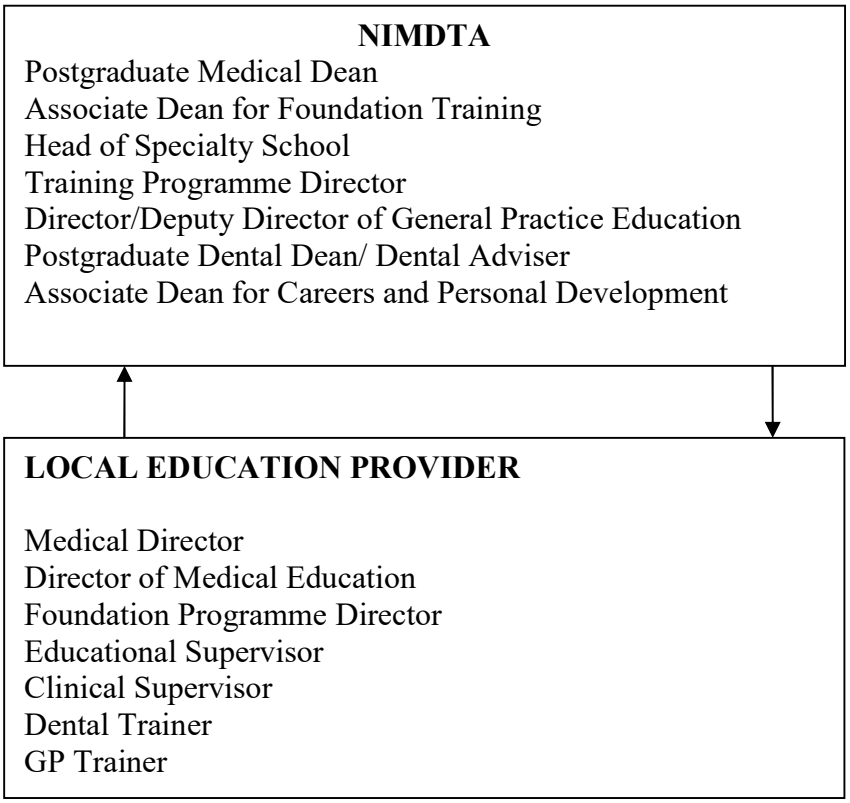
- the subject of a disciplinary process
- has been referred to the GMC or is subject to GMC restrictions
- is the subject of a police investigation
- is the subject of a review of clinical performance on the basis of patient safety concerns
- is subject to any remediation process addressing deficits in clinical performance

- has been absent from employment on health grounds for more than 4 weeks in any rolling year.

7. Assessment and Appraisal

Regular appraisal and assessments are essential to provide feedback on performance and continuing progress and identify educational and development needs. It is important that the assessment and appraisal systems meet GMC requirements and comply with procedures set out in the Gold Guide. Appraisals and assessments must be documented and copies retained. If there are concerns about a trainee's performance the trainee must be made aware of these and given the opportunity to address any shortcomings.

8. Roles and Responsibilities



1) Clinical Supervisor

Trainer with whom the trainee works clinically, and who assesses whether that trainee is safe to carry out the clinical work he/she is expected to do and that he/she progresses within the particular training post/module. This will include direct input to workplace-based assessments.

Responsibility for Trainees Requiring Support

This direct contact with the trainee puts the clinical supervisor in an ideal position

- Detects problems with regard to clinical knowledge and skills, team working, communication, attitude, time keeping, etc.
- Documents any problems observed and discusses with the trainee and brings to the attention of their educational supervisor.
- Trust policies and procedures should be followed as appropriate.

2) Educational Supervisor

Responsible for ensuring overall progress of the trainee through training. Includes responsibility for regular appraisals, collation of workplace-based assessment outcomes and the provision of career advice and support as required.

Responsibility for Trainees Requiring Support

- Should be made aware of and gather evidence about concerns from other team members.
- Discusses these concerns with the trainee during regular appraisals and consider ways of addressing them, with the help of the multi-disciplinary team.
- If problems cannot be resolved within educational supervision context, or in current post, the Educational Supervisor needs to access help from either within the LEP (Foundation Programme Director or DME) or within the Specialty (Training Programme Director, Head of School), depending on the grade of the trainee and the nature of the problem (i.e. health, capability or conduct).
- Fully documents the concerns.

3) Foundation Programme Director

Appointed jointly by NIMDTA and the Health and Social Care Trust; has particular responsibility for Foundation trainees and works closely with the Director of Medical Education and Associate Dean for Foundation Training on all issues regarding Foundation trainees.

Responsibility for Trainees Requiring Support

- Supports trainees within the foundation programme and deals with individual issues
- Supports Educational Supervisors and provides advice on issues concerning individual doctors
- Brings any significant concerns to the attention of the DME and the Associate Dean for Foundation Training

4) Director of Medical Education

Appointed jointly by NIMDTA and the Health and Social Care Trust; manages the Learning and Development Agreement between NIMDTA and the Trust and provides the main link between the Postgraduate Dean and the Trust with regard to the delivery of postgraduate medical and dental training.

Responsibility for Trainees Requiring Support

- Should be made aware of all issues with individual trainees in the Trust
- Provides advice and guidance to trainees, clinical and educational supervisors on matters relating to health, capability and conduct
- Monitors and informs NIMDTA on the progress of trainees in difficulty
- Works closely with Human Resources Department on issues regarding trainees in difficulty, especially where patient safety may be compromised, and invokes Trust procedures as required
- Refers to NIMDTA those problems that cannot be resolved within the Trust

4) Training Programme Director

Appointed by NIMDTA to manage a specialty training programme within the NI Deanery.

Responsible for allocation of specialty trainees to posts, supervision of individual training programmes, regular formal assessment including RITA/ARCP process, problem solving and feedback on progress.

Responsibility for Trainees in Difficulty

- Supports trainees within their programme and deals with individual issues
- Supports Educational Supervisors within their programme and provides advice on issues with individual trainees
- Identifies issues at annual RITA/ARCP review
- Resolves issues within programme (e.g. by moving individual trainee to a different post/supervisor) wherever possible
- Brings more serious problems to the attention of the LEP and NIMDTA

5) Head of Specialty School

Oversees, on behalf of NIMDTA, the activity and proper functioning of the Specialty School; liaises with the relevant College, Faculty or SAC; and supports the Training Programme Directors.

Responsibility for Trainees Requiring Support

- Maintains an overview of trainees requiring additional support within the School and provides general advice and guidance to trainees
- Works closely with the Training Programme Director and Postgraduate Dean on all issues of concern relating to trainees
- Refers trainees to Associate Dean for Careers and Personal Development for specific advice and counselling

6) Associate Dean for Foundation Training

Oversees, on behalf of NIMDTA, the activity and proper functioning of the Foundation School. Responsible for all trainees appointed to the Foundation Programme within Northern Ireland and provides guidance and support to the Foundation Programme Directors and Educational Supervisors

Responsibility for Trainees Requiring Support

- Maintains an overview of foundation trainees in difficulty and provides general support and advice to trainees
- Works closely with the Foundation Training Programme Directors and Postgraduate Dean on all issues of concern relating to trainees
- Refers trainees to Associate Dean for Careers and Personal Development for specific advice and counselling
- Engages with the Medical School on concerns regarding Foundation Year 1 trainees
- Provides direct input to those cases where training may need to be terminated or where appeals procedures need to be invoked

7) Director of GP Education

- Oversees on behalf of NIMDTA the activity and proper functioning of the General Practice Training Department. Responsible for all trainees within the General Practice Specialty Training Programme.

Responsibility for Trainees Requiring Support

- Maintains an overview of GP trainees in difficulty and provides general support and advice to trainees
- Provides support and advice to the Deputy/Associate Directors of General Practice, GP Programme Directors and GP Trainers
- Refers trainees to Associate Dean for Careers and Personal Development for specific advice and counselling
- Provides direct input to those cases where training may need to be terminated or where appeals procedures need to be invoked

8) Postgraduate Dental Dean

- Oversees on behalf of NIMDTA the activity and proper functioning of the Dental Training Department. Responsible for all trainees in general dental practice, hospital and community dentistry

Responsibility for Trainees Requiring Support

- Maintains an overview of Dental trainees in difficulty and provides general support and advice to trainees

- Provides support and advice to the Advisers in Vocational Training and General Professional Training and to the Dental Trainers
- Provides direct input to those cases where training may need to be terminated or where appeals procedures need to be invoked
- Refers trainees to Associate Dean for Careers and Personal Development for specific advice and counselling
- Liaises with the GDC when significant concerns about a trainee have been raised.

9) Associate Postgraduate Dean (Career and Personal Development)

Associate Dean with specific responsibility for trainees requiring careers advice, support and guidance

Responsibility for Trainees Requiring Support

- provides strategic lead and provides guidance and support to the Postgraduate/Associate Deans and Heads of School on individual trainees requiring support.
- Develops and manages framework for dealing with trainees in difficulty
- Assesses and support trainees who require referral to Occupational Health and or remedial training
- Chairs NIMDTA's Trainee Support Group
- Maintains confidential database of all trainees in difficulty

10) Postgraduate Medical Dean

Overall responsibility for postgraduate training and education within the Northern Ireland Deanery.

Responsibility for Trainees Requiring Support

- Appointed as Responsible Officer (RO) for NIMDTA with responsibility for making recommendations to the GMC in relation to the revalidation of trainees
- Responsible for ensuring that processes are in place within LEPs for dealing with concerns in relation to a trainee's fitness to practice
- Provides support and advice to the Associate Deans, GP Director and Heads of School
- Provides direct input to those cases where training may need to be terminated, or where appeals procedures need to be invoked
- Liaises with Trust Directors of Medical Education and Medical Director and GMC, where appropriate, when significant concerns about a trainee have been raised.

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11) Trainee Support Group

Its purpose is to support the Quality Management Group in the delivery of the business of the Agency, by providing a cross agency working platform in relation to the area of Trainees in Difficulty. The Group will have a particular focus on ensuring a consistent approach to policies and procedures in relation to trainees in difficulty across the NI Deanery, providing a forum for the sharing of good practice, and to ensure that such confidential information is stored, retrieved and shared in an appropriate manner.

Roles and Responsibilities as follows:

a) to oversee the use of the Trainees Requiring Support Policy, and ensure that this policy remains fit for purpose;

b) to ensure that the Agency meets the standards of GMC and COPDEND in relation to this area of work;

c) to oversee the promotion of good practice with regard to this area of work within the Agency;

d) to support the Postgraduate Dean in his role as responsible officer with regard to revalidation and trainees about whom there are significant concerns;

e) to establish, and then oversee the use of, a centralised database recording the Agency's work in this area;

f) to share experiences of good and bad practice, through the use of anonymous case studies;

g) to avoid isolated decision making through the provision of peer support;

h) to identify training needs and the procurement of such training for appropriate persons;

i) to identify partner organisations with experience in this area, to establish working relationships with;

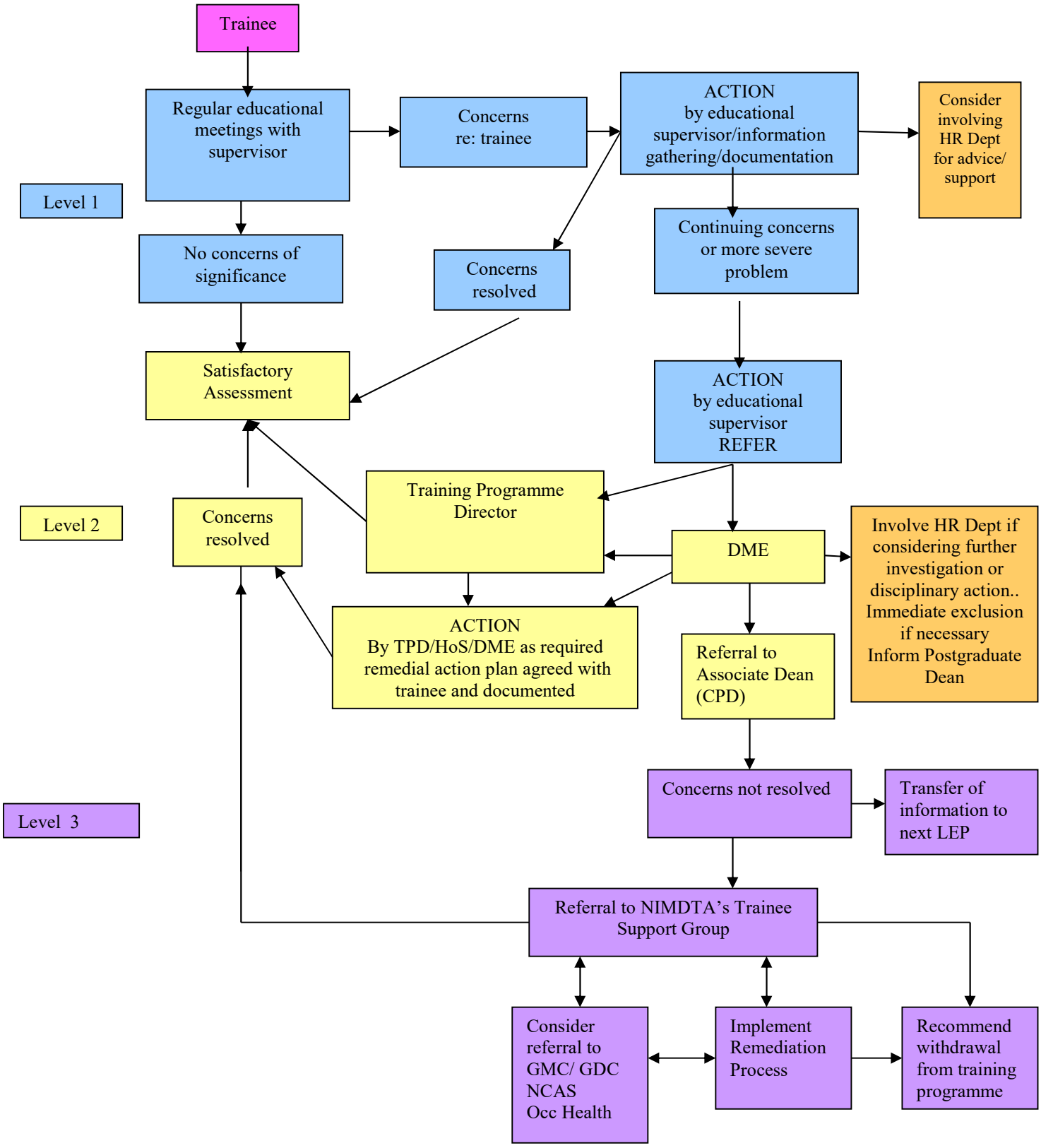
j) to discuss further issues that may be delegated from time to time.

2. COMPOSITION AND MEMBERSHIP

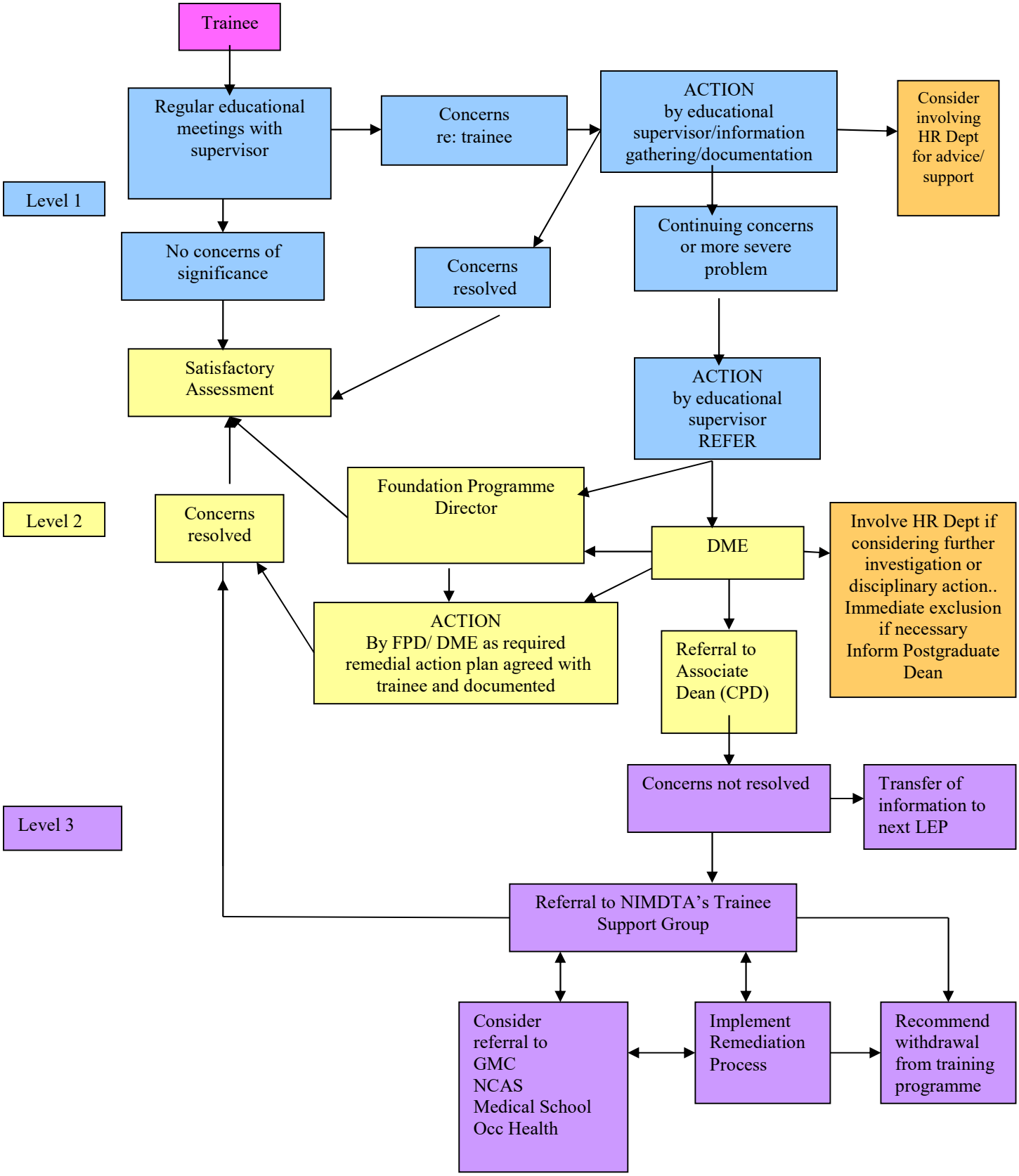
2.1 The Group consists of the Associate Dean for Careers and Personal Development (Chair), the Postgraduate Dean, the Associate Dean for the Foundation Programme, the Associate Dean for Quality and Secondary Care, the Postgraduate Dental Dean, the General Practice Director, the Administrative Director, and the Corporate Governance Manager.

APPENDIX 1

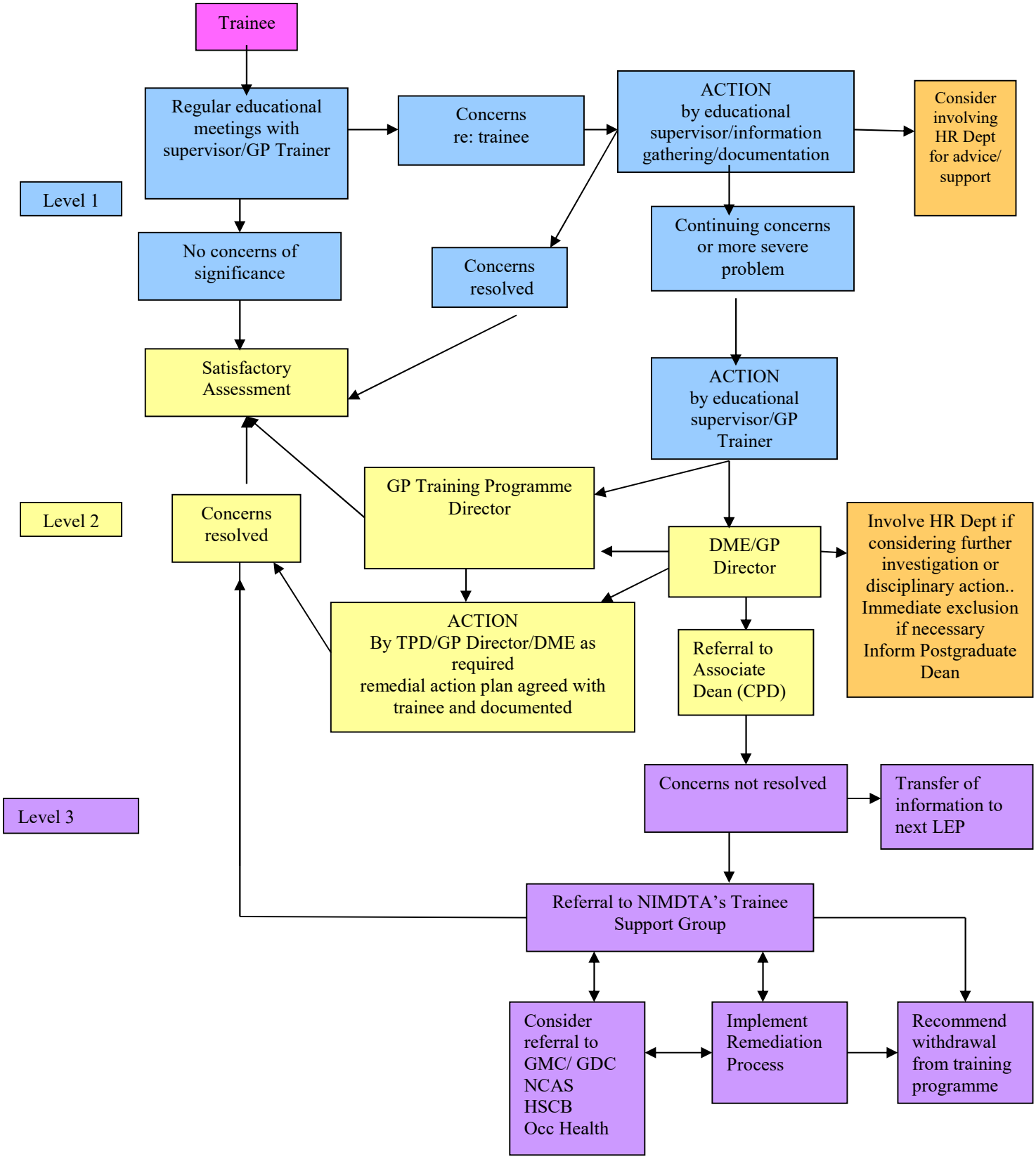
Trainees in difficulty – Process Flowchart for Specialty Training



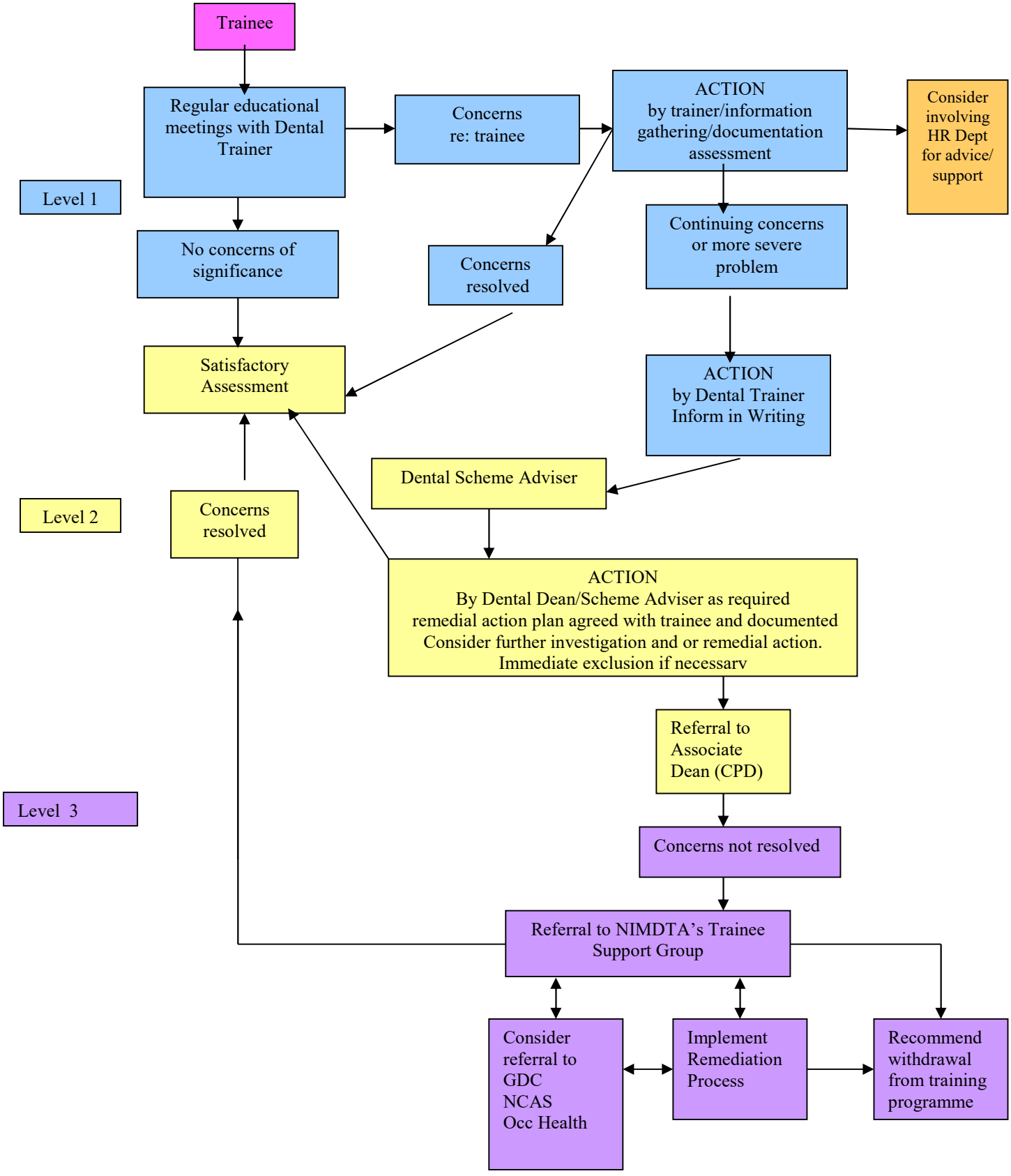
Trainees in difficulty – Process Flowchart for Foundation Training



Trainees in difficulty – Process Flowchart for GP Training



Trainees in difficulty – Process Flowchart for Dental Vocational Training



Level 1

The aim of Level 1 is to identify trainees needing specific help and support as early as possible in order to avoid difficult situations where problems have developed to such an extent that their solution requires major intervention. Regular appraisal and assessment of a trainee's performance by educational supervisors/trainers is an important opportunity to identify and deal with the majority of problems within the trainee's current educational setting.

Where concerns are identified by a supervisor/trainer these should be discussed openly with the trainee and further information gathered from other members of the team. These should be formally documented. Where subsequent assessments reveal no improvement the educational supervisor/trainer should seek further help and support.

Concerns relating to trainees in the dental vocational training/general professional training schemes should be referred to the Scheme Adviser. The Adviser should be notified in writing in order that progress can be monitored.

Level 2

In certain situations e.g. major clinical incident the most appropriate course of action will be to follow the disciplinary procedures of the LEP (in accordance with the 'Maintaining High Professional Standards' framework). However the Director of Medical Education (DME) and NIMDTA should always be informed that such an action has been undertaken.

More commonly the next step would be to involve the DME (see Appendix 1). If the problems have implications for progress in training the advice of the training programme director/Head of School or Associate Dean for Foundation Training should be sought. For General Practice trainees the appropriate contact will be the Director/Deputy Director of GP Education and for Dental trainees the Postgraduate Dental Dean/Dental Adviser. The Dental Adviser will be responsible for ensuring that the action plan, detailing review dates, is agreed with both trainee and trainer. The trainer will be invited to meet with the Dental Dean/Adviser to confirm that he/she is prepared to supervise the implementation of the plan.

Many problems will be resolved by local intervention. This will include assessment of need, further documentation and where appropriate remedial action with the support of the local consultant(s)/educational supervisor(s) and their team(s).

Level 3

This level of intervention will be required for a minority of trainees in difficulty who have been identified by LEPs as having difficulties which either have not been resolved by local intervention, or which require further input which is not available locally.

All trainees fulfilling these criteria must be referred to NIMDTA who will undertake further assessment of the needs of the particular trainee and involve HR and Occupational Health

as appropriate. Such cases will be discussed by NIMDTA's Trainee Support Group (terms of reference in Appendix 3).

Where appropriate the trainee will be referred to the Associate Dean for Careers and Personal Development for support and counselling.

Trainees who have been identified with significant problems will be referred to the NIMDTA's Trainee Support Group to agree an appropriate plan of action.

All attempts at targeted training will need to be recorded and monitored with clear indications of how progress has been assessed. Such systems as are agreed and planned for implementation may need to be discussed with Chief Executives, Medical Directors and DMEs. This is not just a matter of courtesy but to ensure that the systems link into Trust based systems for clinical risk management and clinical governance. Trainers responsible for supervising trainees in general medical or dental practice will receive written notification if it has been agreed that the trainee should not return to practice

FITNESS TO PRACTICE

Where a concern about a trainee's performance arises, the GMC (or GDC) and the National Clinical Assessment Service (NCAS) may be approached. NCAS is part of the National Patient Safety Agency and can facilitate case conferences and advise on how to investigate performance concerns. It also offers specialist expertise in assessing complex cases.

If the concern, whether of performance, health or conduct, is so serious as to call into question the trainee's fitness to practice, then the regulator's (**GMC/GDC**) advice should be taken. This approach will therefore only be used in the most serious circumstances.

In all other circumstances, such as immediate concerns that might require exclusion or suspension, general concern about a practitioner's performance, conduct or competence, and in any situation where the local organisation is unsure how to proceed, **NCAS** should be contacted.

APPENDIX 2

Checklist for educational supervisors/trainers: how to diagnose and manage a trainee in difficulty

Symptoms and Signs

Is your trainee demonstrating any of the following?

Anger; rigidity/obsessive behaviour; emotionality; absenteeism; failure to answer bleeps; poor time keeping or personal organisation; poor record-keeping; change of physical appearance; lack of insight; lack of judgement; clinical mistakes; failing exams; discussing a career change; communication problems with patients, relatives, colleagues or staff?

Have there been complaints from patients or staff about any of the following?

Bullying; arrogance; rudeness; lack of team working (e.g. isolation; unwilling to cover for colleagues; undermining other colleagues; criticising or arguing in public/in front of patients); defensive reactions to feedback; verbal or physical aggression; erratic or volatile behaviour

Underlying reasons/explanations

Can you identify any reasons for the above signs and symptoms – for example?

Poor approach to studying; lack of knowledge; lack of skills; lack of confidence; deficient interpersonal skills; language barrier; attitudinal /personality problem; stress due to life events; stress due to work (e.g. dysfunction in the team; problems with trainer/supervisor or the training process; a specific critical incident affecting confidence); poor motivation; health problems; drug or alcohol abuse; physical illness; psychiatric illness; workload; sleep deprivation.

Is the problem due to any of the following factors within the individual?

Capacity – a fundamental limitation that will prevent them from being able to do their job (e.g. mental or physical impairment) even with all reasonable adjustments in place.

Learning – a skills deficit through lack of training or education. In these cases, skills-based education is likely to be appropriate, provided it is tailored as closely as possible to the individual learning style of the trainee and is realistic within exiting resources.

Motivation – a drop in motivation through being stressed, bored, bullied or overloaded – or conversely being over-motivated, unable to say no, anxious to please, etc. In these cases some form of mentoring, counselling or other form of support may be appropriate and /or addressing organisational issues like workload, team dysfunction or other environmental difficulties that may be affecting motivation.

Distraction – something happening outside work to distract the doctor; or a distraction within the work environment (noise or disruption; team dysfunction). The trainee may need to be encouraged to seek outside professional help if the problem is outside work.

Health – an acute or chronic health problem which may in turn affect capacity, learning or motivation. Occupational health may have a role here; or the trainee may need to be encouraged to visit his or her GP.

Alienation – a complete loss of any motivation, interest of commitment to medicine or the organisation, leading to passive or active hostility, “sabotage” etc. This cannot generally be rectified and damage can be caused to others (patients and colleagues) and to the organisation if allowed to continue for too long. The trainee should be moved out of the organisation, with whatever support or disciplinary measures may be deemed appropriate.

Investigation

Have you talked to the trainee to gain their perspective?

Have you talked to staff/colleagues confidentially to verify your findings?

Is there any documentary evidence?

Can you talk to other professionals concerned with the trainee’s welfare e.g. GP (with their permission)?

Management

Have you clearly established (within the grounds of medical confidentiality) that any existing health issues are being managed by the trainee’s GP or specialist?

Is an Occupational Health Consultant advising NIMDTA regarding fitness to work in both the short and long term?

Has a Fitness to Practice referral been made to the GMC/GDC?

Have you clearly documented any information or evidence you have discovered?

Have you discussed the purpose of this documentation with the trainee?

Does the trainee understand that the appraisal process is confidential but that some documentation of problems is necessary for regulatory purposes and can you agree on this?

Can and should the trainee remain at work?

Is this a case for a trust disciplinary procedure or referral to the GMC/GDC?

Management Plan

Have you developed and agreed a suitable learning plan with the trainee?

Can you organise and commit to increased and regular supervision?

When will re-appraisal and reassessment take place?

If problems are not or cannot be resolved should this be referred on to the Director of Medical Education /training programme director/NIMDTA?

Further guidance about how and when to act on these concerns is provided below in the Process Flowchart (Appendix 1).

If there appears to be an issue of a possible career mismatch or incorrect career choice, has the trainee received appropriate guidance from the Programme Director, Head of School or Associate Dean for Careers and Personal Development?

NHS

Revalidation Support Team

NI Responsible Officer Forum Meeting

1. Quality assurance of appraisal/appraisers
2. Identifying and managing concerns

Dr Martin Shelly

Revalidation Support Team

2nd February 2012

NHS

Revalidation Support Team

Quality assurance of appraisal and appraisers

- What assurance does the RO need?
- Model of appraisal
- GMC supporting information
- QA appraisers
- QA appraisal system

NHS

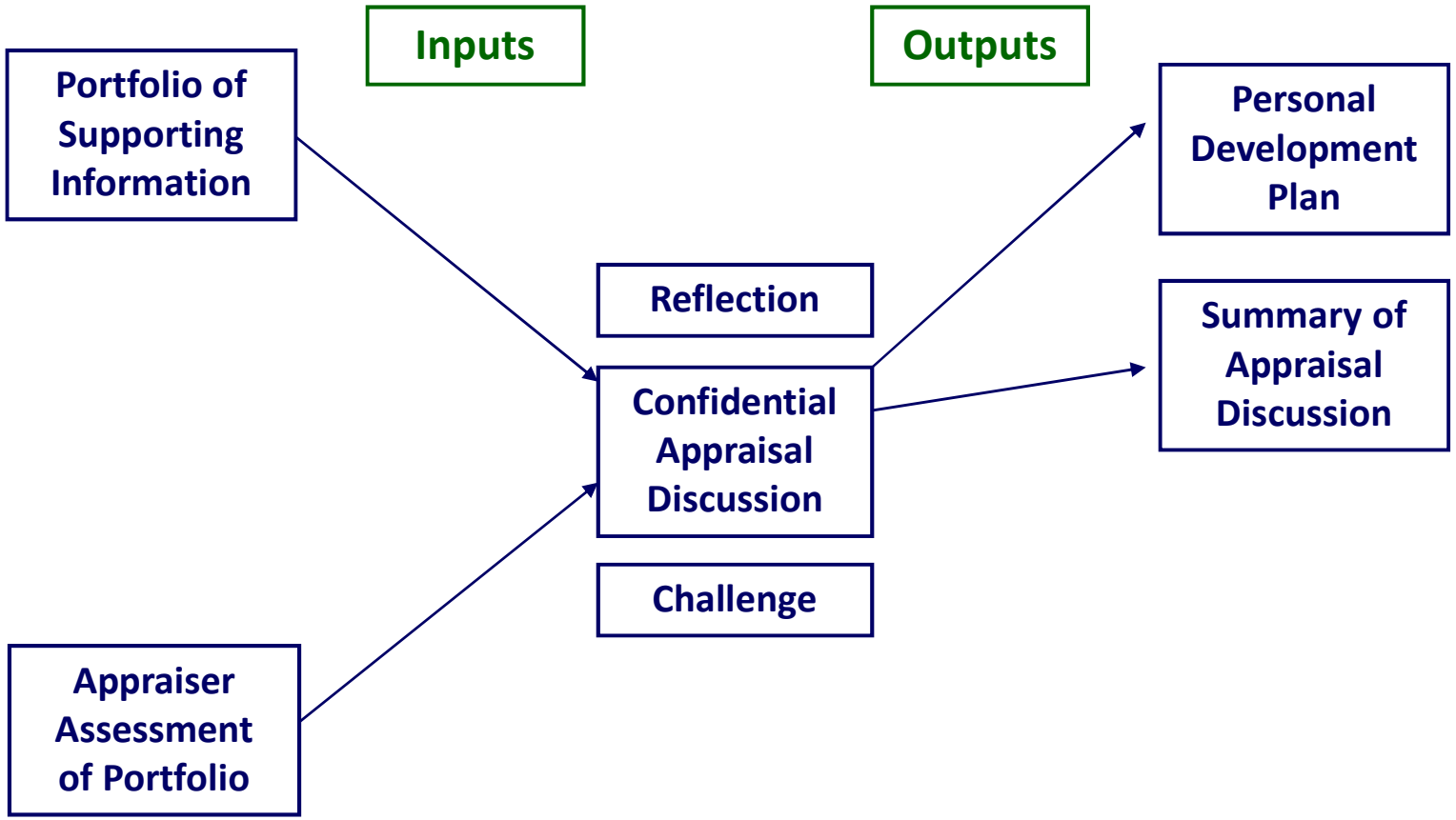
Revalidation Support Team

What assurances do you need from the appraiser after the appraisal?

NHS

Revalidation Support Team

Medical Appraisal Model



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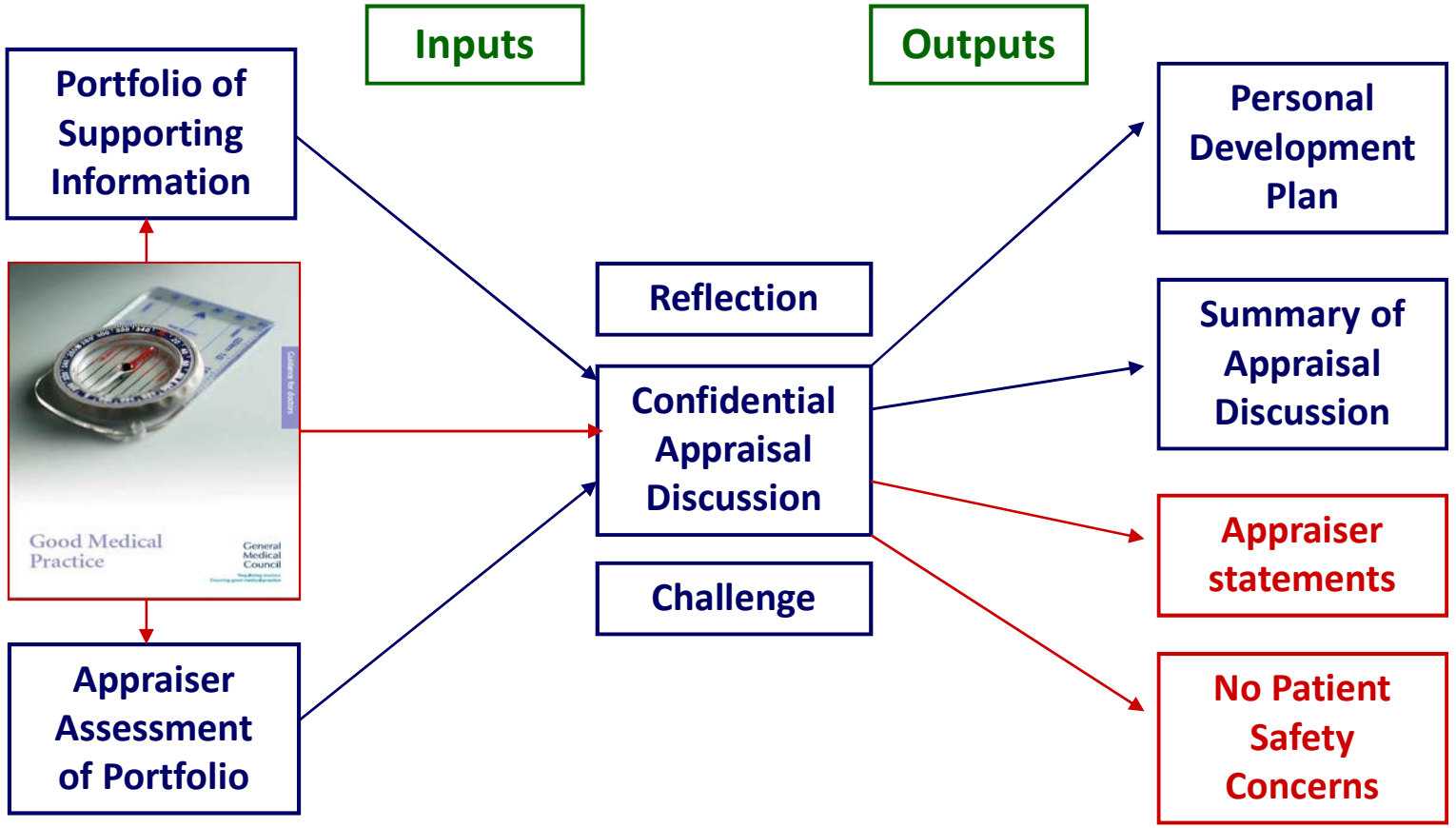
Revalidation Support Team

Medical Appraisal Model



NHS

Revalidation Support Team

GMC Guidance on Supporting Information

‘The supporting information that you will need to bring to your appraisal will fall under four broad headings:

1. **General information** – providing context about what you do in all aspects of your work
2. **Keeping up to date** – maintaining and enhancing the quality of your professional work
3. **Review of your practice** – evaluating the quality of your professional work
4. **Feedback on your practice** – how others perceive the quality of your professional work’

Supporting information for appraisal and revalidation. GMC, March 2011

NHS

Revalidation Support Team

GMC Guidance on Supporting Information

'There are six types of supporting information that you will be expected to provide and discuss at your appraisal at least once in each five year cycle. They are:

1. Continuing professional development
2. Quality improvement activity
3. Significant events
4. Feedback from colleagues
5. Feedback from patients (where applicable)
6. Review of complaints and compliments'

Supporting information for appraisal and revalidation. GMC, March 2011

NHS

Revalidation Support Team

Competencies

- Professional responsibility
  - Credibility, role model, champion
- Knowledge and understanding
  - Understand appraiser role, legislation, GMC requirements
- Professional judgement
  - Review portfolio, judge engagement, patient safety issue, emerging performance issue, PDP
- Communication skills
  - Facilitate effective appraisal discussion, produce quality outputs, deal with any issues or concerns that arise
- Organisational skills
  - Timely responses, sufficient computer skills, e-portfolios

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‘Assuring the Quality of Appraisers’

- Recruitment and selection of appraisers
  - Core elements of person specification and job description
- Training for appraisers
  - Skills, knowledge, behaviour
- Development and support of appraisers
  - Methods of ongoing support
- Performance review of appraisers
  - Feedback on performance in the role
  - Quality of outputs
  - Methods of assessment

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Quality assurance of appraisal

Which parts of the appraisal system can be quality assured?

- Management of appraisal system
  - Exception audit of missed or incomplete appraisals
- Inputs of appraisal
  - Portfolio of supporting information
  - Appraiser evaluation of portfolio
- Outputs of appraisal
  - Quality of PDP
  - Quality of summary of appraisal
- Appraisers
  - Selection, training, support and performance review

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Key Messages:

- The appraisal system needs to provide the level of assurance the RO needs
- Appraisal needs to cover all the doctor's work
- Quality assurance of the appraisal system is important so the RO can rely on the outputs
- ORSA suggests
  - Exception audit
  - Ensure all appraisers have received basic training
  - Some simple quality assurance of outputs of appraisal
  - Feedback to appraisers

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Responsible Officer Forum Meeting

1. Quality assurance of appraisal/appraisers
2. Identifying and managing concerns

Dr Martin Shelly

Revalidation Support Team

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Identifying and managing concerns

- Fitness for purpose and fitness to practise
- The range of concerns and issues:
  - knowledge, skills, performance, conduct/behaviour and health
- Thresholds for intervention
- Good practice principles for performing investigations
- Good practice principles for support programmes, rehabilitation and remediation
  - Formal action plan agreements and behavioural contracts

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Fitness for purpose and fitness to practise

What is the difference between ‘fitness for purpose’ and ‘fitness to practise’?

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Fitness for purpose and fitness to practise

Fitness for purpose:	Fitness to practise:
Expected standards for specialty/grade	Minimum standards for specialty/grade
Set by employer or commissioner	Set by GMC [generic] and College [specialty]

- Considerable overlap
- The thresholds may not be the same [GMC may accept a doctor is fit to practise but the employer may have continuing concerns about their fitness for purpose]
- Employers/commissioners should not rely on GMC procedures to sort out fitness for purpose issues

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Concerns

May arise from:

- Clinical knowledge, skills, performance
- Behaviour
- Health
- Working context

Presentation, evidence and information may reveal a mixed picture

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Concerns – the data

- Clinical – including safety and governance – 65%
- Behaviour/misconduct - 56%
- Health concerns – 24%

- Concerns rarely come on their own!
- The overlaps: 22% clinical/behavioural
  7% clinical/health
  4% behavioural/health
  7% clinical/behavioural/health

Data: NCAS 2007-2009

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Health concerns

- Anxiety/stress/burnout: 6%
- Depression/hypomania: 6%
- Substance/alcohol misuse: 8%
- Indicators of cognitive impairment: 5%
- Manual dexterity: 2%
- Mobility/lifting and carrying/sight/speech: 2%

[Source NCAS, n = 1472 advice cases]

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Behaviour

- Communication with colleagues – 1 in 5
- Team working – 1 in 7
- Communication with management – 1 in 8
- Conflict management style – 1 in 20
- Leadership style – 1 in 20

[Source NCAS, n = 1472 advice cases]

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Disruptive behavior

- Aggressive behavior – 1 in 13
- Behaviour under pressure – 1 in 14
- Erratic/unpredictable behaviour – 1 in 25
- Bullying/harassment/discrimination – 1 in 30

[Source NCAS, n = 1472 advice cases]

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Clinical knowledge and skills

- Clinical concerns in 41 out of 50, including:
  - Clinical knowledge
  - Clinical decision-making (including making a diagnosis)
  - Prescribing
  - Record keeping, guidelines, policies and procedures.

[Source NCAS, n = 50 Assessment cases]

Is there a real concern?

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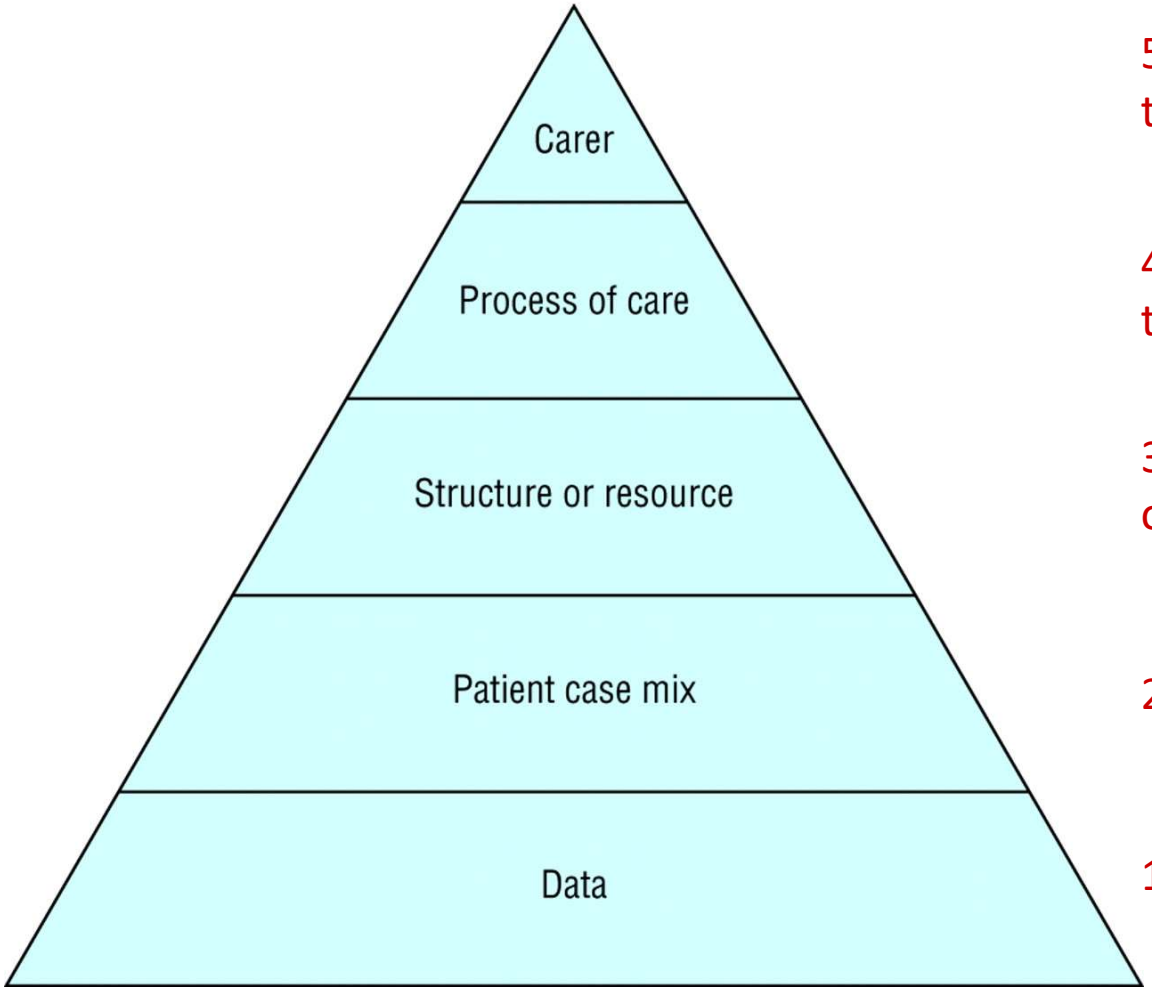
Pyramid model of investigation to find cause for high patient mortality



5. Is there an issue with the practitioner?

4. Is there an issue with the process of care?

3. Is there an issue with the organisation or resource?

2. Are there case mix issues?

1. Is the data correct?

Mohammed M A et al. BMJ 2004;328:1474-1477

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Decisions = Thresholds

Is there a concern?	Preliminary Investigation?
Is there a significant patient safety issue?	Suspension?
Is there an immediate GMC/Police issue?	Immediate referral?
Is a formal investigation/assessment proportionate?	Who should investigate?
What is the confirmed ‘diagnosis’?	Practise? Health? Conduct?
What is the ‘management plan’ or ‘action plan’?	What is desired outcome? Internal? External? Training? Supervision? Suspension? OHD? Etc?
What further review is required?	
Are the systems and processes fair/consistent?	How do I know?

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Thresholds for intervention

Briefly discuss the scenarios around the tables

What are your options at this stage?

What additional information do you need to decide what to do?

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When Concerns Arise: General Principles

The Responsible Officer must:

- understand the different types of concern
- understand the relevant regulations and national guidance
- know where to go for advice and help
- set up policies and procedures for responding to concerns
- appoint properly trained investigators
- understand options for intervention using appropriate internal and external resources
- put appropriate review in place

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When Concerns Arise: General Principles

The Responsible Officer must:

- work to a consistent and equitable set of thresholds for intervention
- be aware of the influences on their own decision-making
- ensure that they can ‘calibrate’ their decision-making [case discussion with other ROs, training and workshop sessions]

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GMC threshold for referral is likely to be met if:

- Actions have harmed patients or put patients at risk of harm
- Attempts to improve a doctor's performance have failed and an unacceptable risk to patient safety remains
- Trust/PCT has significant concerns about doctor leaving employment - not confident other safeguards in place
- Deliberate or reckless disregard of clinical responsibilities towards patients
- Abused a patient's trust or other fundamental rights
- Behaved dishonestly or fraudulently
- Behaviour undermines public confidence in doctors generally
- A doctor's health is compromising patient safety

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Thresholds for GMC involvement in ill-health

Can be managed locally if:

- Insight
- Seeking treatment
- Following advice
- Appropriately restricting practice
- Supported

Unless:

- Significant misconduct (even if driven by illness)

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Good practice in investigation

An investigation is appropriate if there is evidence to suggest that the doctor may:

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

NCAS: How to conduct a local performance investigation. 2010

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Good practice in investigation

Support the Practitioner

Explain and answer questions about:

- Terms of reference, timescales, process
- Regulations governing the case
- Reasons for any restrictions or suspension
- Content of proposed statements to patients, colleagues, media
- Personal support

NCAS: How to conduct a local performance investigation. 2010

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Good practice in investigation

Protect the Organisation

Take care not to put the investigators and decision-makers in positions where they might appear later not to be acting impartially

- Investigators should not be involved in decisions to take formal action or in subsequent procedures
- CEO will be involved in formal decision making process so should be informed only of broad nature of concerns and process decisions
- Concurrent grievances and complaints should be investigated by someone not otherwise involved

NCAS: How to conduct a local performance investigation. 2010

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Good practice in investigation

Terms of Reference should define

- The issues to be investigated
- The boundaries of the investigation
- The period under investigation
- The timescale for completion of report

- ToRs should prevent unfocussed or ‘general’ investigation

NCAS: How to conduct a local performance investigation. 2010

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Good practice in investigation

Case Manager

- MHPS requires this to be the Medical Director for cases involving consultants or clinical directors
- Appoints investigator and ensures investigation process is efficient
- Makes recommendations on the basis of the report
- No conflict of interest

NCAS: How to conduct a local performance investigation. 2010

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Good practice in investigation

Investigator

- Appropriate training and experience
- Planning of the investigation: documents and interviews
- Records the process
- Collecting and weighing the evidence
- Findings of fact
- Conclusions

NCAS: How to conduct a local performance investigation. 2010

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Good practice in investigation

Weighing the evidence

- What is the evidence and is it written?
- How recent is the evidence?
- How direct is the evidence?
- How credible and compelling is the evidence?
- How reliable is the source?
- Does the evidence require technical interpretation
- Is there a pattern to allegations against the practitioner?
- Is there evidence from previous investigations?

NCAS: How to conduct a local performance investigation. 2010

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Outcomes of Investigation

EXERCISE: 20 minutes

Discuss the additional scenarios around the tables.

What are your options at this stage?

What additional information do you need to decide what to do?

Which option will you take and why?

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Good practice in investigation

Report and Decision Making

- Maintain confidentiality by limiting information to those who need to know [practitioner, case manager, responsible manager]
- Responsible manager should decide and record reasons for circulating further
- Report informs decision on
  - whether concerns are unfounded or confirmed
  - whether or not further action is needed
  - the type of action

NCAS: How to conduct a local performance investigation. 2010

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Good practice in investigation

Potential outcomes of investigation

- Does it require further action?
- Is there evidence of a concern which may need formal action?
  - Conduct?
  - Health concerns?
  - Capability?
- Is there a need for restrictions on practice or exclusion/suspension to enable further investigation or action?
  - What do we need to put in place to bring the situation under control?
  - Can we rely on an agreement reached?
- Should the case be referred to the Regulator?

NCAS: How to conduct a local performance investigation. 2010

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Good practice in intervention

Hallmarks of an appropriate, effective intervention

- Tailored to the problem
- Suits the individual's learning style
- Results in genuine, long lasting change
- Requires an acceptable investment of time, money, energy or other resources
- Makes a quantifiable difference
- Clarity and client engagement are essential
- Personality, motivation and organisational factors all impact on individual performance

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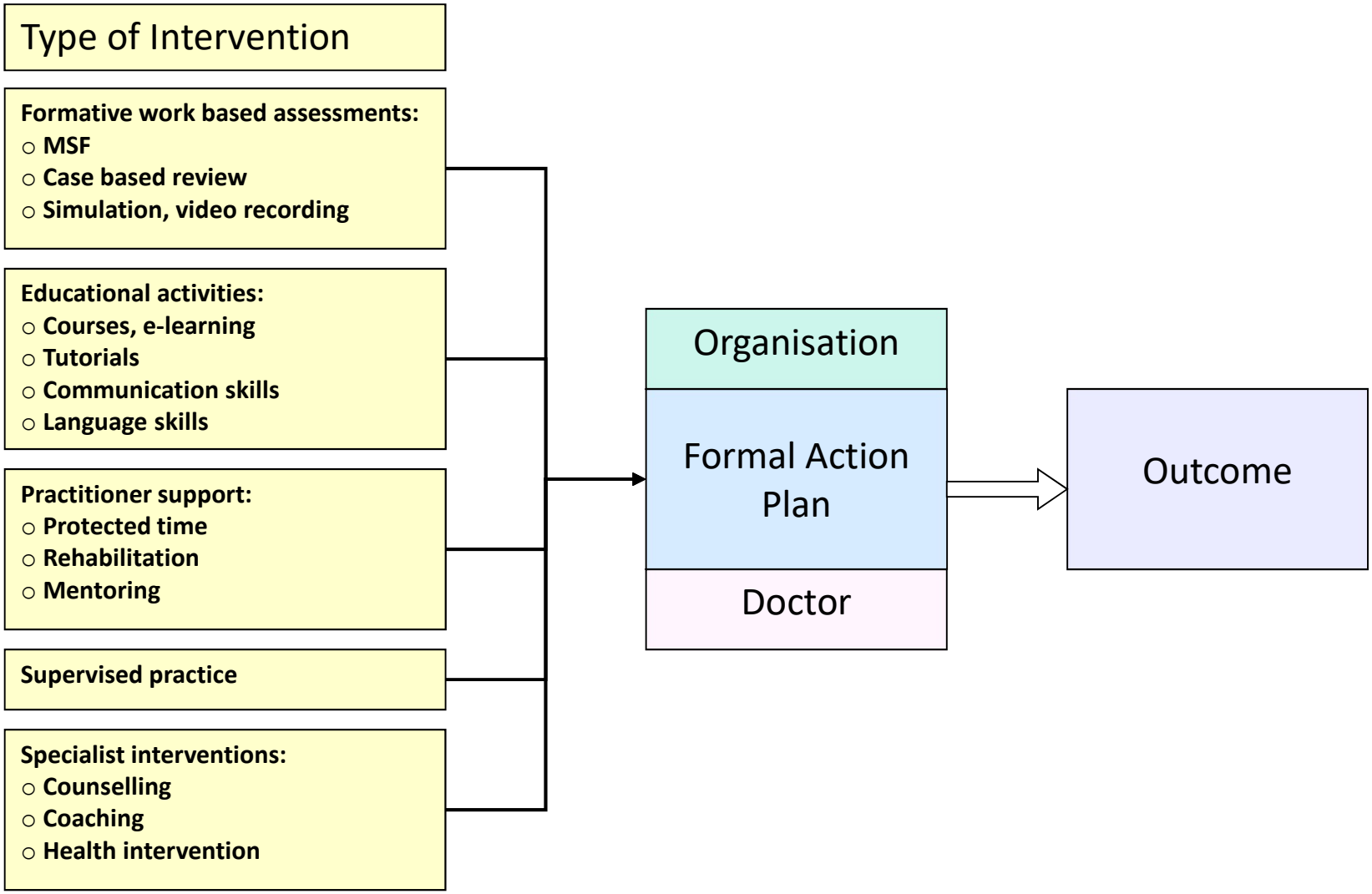
Good practice in intervention



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Good practice in intervention

Formal action plan agreements:

- An action plan is a developmental/educational contract between the doctor and the employer/contracting body
- Describes how the doctor's identified needs (clinical, behavioural and/or health) should be addressed.
- Must be practical, feasible and affordable
- Must be clear and sufficiently detailed in terms of:
  - personal objectives ['SMART']
  - support arrangements
  - process for monitoring and review/re-assessment
  - outcomes
- Timelines must be explicit, feasible and fair

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Good practice in intervention

Range of interventions:

- Supervised practice
- Formative work based assessments
  - case based reviews, Mini-Cex, OSCEs, OSATS, video recording, simulation, MSF
- Educational activities [retraining/reskilling]
  - tutorials, workshops, courses, e-learning, focused reading, language/communication skills-based activities
- Specialist interventions
  - behavioural coaching, health interventions, counselling (career or therapeutic)
- Practitioner support
  - mentoring, vocational rehabilitation, protected learning and development time

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Good practice in intervention

Behavioural contracts

- Must outline explicitly what is expected of the doctor
- Describes behaviours that must:
  - cease
  - change
  - be adopted
- Timeframes must be explicit
- Mechanisms for monitoring behavioural change (MSF, coaching/mentoring, peer networks) must be clearly defined

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Good practice in intervention

Health interventions

- Assessment of health state
- Occupational health package:
  - risk assessment
  - coordination of care
  - management of rehabilitation and return to work
- Specialist health support and treatment

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Good practice in intervention

Predictors of a good outcome:

- Desire to change
- Motivation
- Insight
- Reflection
- Capable of change
- Conscientious
- Resilience
- Support available [personal and organisational]
- Work environment and culture

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Possible Outcomes

1. The practitioner demonstrates that the concerns about their practice have been resolved

2. There is evidence that practitioner has been unable to address the concerns and other options need to be considered

   - Capability/disciplinary procedures
   - Performers List/contract action
   - Change in job plan (restricted duties)
   - Retirement (early, age, ill health)
   - Negotiated settlement
   - Regulator involvement
   - Health Professional Alert Notices

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Steps dictated by framework document

			Date:	Noted?
Preamble	How did the concern first arise?	Expressed by other staff		
		Review of performance against job plan or appraisal		
		Monitoring of data on clinical performance and quality of care		
		Clinical governance, clinical audit, other quality improvement initiatives		
		Complaints		
		Information from regulatory body		
		Litigation		
		Information from police or coroner		
		Court judgements		
		Following critical incidents or near misses		
		Other		
Action when a concern first arises:	Clarify what has happened and the nature of the concern	Decision as to whether formal or informal approach necessary - clinical manager needs to involve the MD and HR Director, with advice from NCAS if necessary.		
	Has the Chief Executive been informed (all cases)?			
	Consider discussing the case with NCAS	Can this case be progressed by mutual agreement and if so would NCAS assessment help? If the practitioner will not co-operate with such a referral and an underlying health issue is not the reason, then disciplinary action may be needed.		

	Consider whether urgent action is needed to protect patients	Can this be done informally by mutual agreement?		
	Consider whether restriction of practice or exclusion is required	Can we arrange supervision of normal clinical or contractual duties? Can we restrict the practitioner to certain duties? Can we restrict to non-clinical duties? (this could include retraining if mutually agreed) Does the individual need sick leave? Have we discussed with NCAS?		
	Is formal approach required under either conduct or clinical performance procedures?	If informal approach taken then NCAS can help with local action plan or more detailed assessment If formal approach required, the Chief Executive must appoint (with the support of Director of HR): • a Case Manager • a Case Investigator • a Designated Board Member Establish an audit trail for all actions of the investigating team including what happen after the report is finalised		
	Case Investigator's Role	Must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director and the Director of HR		
	Case Manager's Role	Inform the practitioner of the name of the Case Investigator and the specific concerns. Practitioner should see all correspondence relating to the case together with a list of the people whom the C I will interview Is any additional expertise required either at the outset or as the work progresses? Decision making process is outlined at para 38, page 12. If the exclusion requires to be extended the C M must report to Trust Board and after third review must report to CE also		

		If reasons for exclusion cease to exist then CM mus arrange for practitioner to return to the workplace with appropriate support.		
Restriction of practice and exclusion from work	Immediate exclusion (see page 9) doesn't require a formal allegation. Must not last any more than 4 weeks.	Clinical Manager must explain to the practitioner why an immediate exclusion is justified. Convene a case conference to allow more measured consideration, if necessary. Allow practitioner opportunity to state their case and propose an alternative to exclusion (further training, referral to Occupational Health, referral to NCAS) Ensure practitioner understand that he can have a companion (page 10, para 30). Notify GMC		
	Case conference to decide formal exclusion (within 4 weeks of immediate exclusion)	Must involve (as a minimum) • Clinical Manager • Medical Director • Director of HR Case Investigator must produce a preliminary report for that case conference. This is advisory to enable the Case Manager to decide on the next steps as appropriate. The report should provide sufficient information for a decision as to whether • The allegation appears unfounded • There is a misconduct issue • There is a concern about clinical performance • The case is complex and requires further detailed investigation before advice can be given Can the practitioner return to work in a limited capacity?		
	Meeting with practitioner	The practitioner should be told the reasons why formal exclusion is considered to be the only way to deal with the		

		case. The practitioner should be given the opportunity to state their case and propose alternatives to exclusion. The discussion must be minuted and a copy given to the practitioner.		

Roberts, Naomi

From: O'Carolan, Donncha
Sent: 07 February 2012 15:40
To: Garrett, Elizabeth
Cc: Reid, Simon
Subject: FW: Meeting Wednesday 8th February, 11am - Revision of Maintaining High Professional Standards Focus Group
Attachments: CiC_Dr M Shelly Presentation_NI RO forum slides 020212.PPT

Liz,

Would you run off a copy of this for Simon, he'll need it for the meeting tomorrow morning.

thanks,

Donncha

From: Hutchison, Ruth
Sent: 07 February 2012 15:10
To: 'Barkley, Mervyn'; Roberts, Margot; Kilgallen, Anne; Reid, Simon
Cc: 'Davey, Noreen'; Dardis, Pauline; Beck, Lorraine; Henderson, Elizabeth; O'Carolan, Donncha; Woods, Paddy
Subject: Meeting Wednesday 8th February, 11am - Revision of Maintaining High Professional Standards Focus Group

Dear Colleagues

I have attached for information prior to the meeting tomorrow a copy of a training presentation delivered last week to the Responsible Officer Forum members by Dr Martin Shelly of the Revalidation Support Team (NHS).

The second half of the presentation relates to identifying/managing concerns.

Thank you

Regards
Ruth

Ruth Hutchison
Programme Support Officer
Confidence in Care Programme
Room C3.20, Castle Buildings
Belfast BT4 3SQ

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

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M AINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY

APPENDIX 1

PROCESSES FOR EXCLUSION FROM WORK

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

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

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

3 The Directions require that HSC bodies must ensure that:

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

MANAGING THE RISK TO PATIENTS

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

5 The purpose of exclusion is:

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

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

THE EXCLUSION PROCESS

7 **Under the Directions, an 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 of exclusion from work

8 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

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

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

Commented [JL1]: ? extended

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

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

12 Formal exclusion of one or more clinicians must only be used where:

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

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

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

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

15 The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 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.

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

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

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

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

Exclusion from premises

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

where the practitioner may present a serious potential danger to patients or other staff

Keeping in contact and availability for work

20 Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the 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).

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

Informing other organisations

22 Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on

practice or exclusion and provide a summary of the reasons. Details of other employers (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[1] Ref Information Sharing Guidance

23 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.

24 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

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

[1] 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.

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[2]. 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.

[2] 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.

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 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.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY

APPENDIX 2

CONDUCT HEARINGS AND DISCIPLINARY PROCESSES

CONDUCT HEARINGS AND DISCIPLINARY PROCESSES

1 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.

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 (paragraphs 149-204 refer).

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[1].

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

5 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.

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

(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[2];
(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

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.

Commented [JL1]: Check reference is up to date

[2] 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.

13. 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

14. 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

15. 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.

16. 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).

17. 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.

18. 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.

19. 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

20. 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

21. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[3].

22. 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 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

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

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.

23. 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

24. 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

25. 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.[4] 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.

26. 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.

27. 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.

28. 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.

[4] 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

29. 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.

30. 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

31. 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.

32. 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

33. 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.

34. 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.

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

36. 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.

37. 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.

38. 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.

39. 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

40. 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.

41. 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.

42. 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).

43. 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

44. 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.

45. 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

46. 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.[5] 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[6] who must also have the appropriate training for hearing an appeal.

47. 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

48. 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[7];
- a senior Human Resources specialist.

49. 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.

50. 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

[5] See Annex A.
[6] 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.
[7] Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

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.

51. 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.

52. 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

53. 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.

54. 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.

55. 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

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

57. 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.

58. 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.

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

Decision

60. 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

61. 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

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

63. 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.

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

Creating and administering the list

65. 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

66. 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.

67. 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.

68. 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.

69. 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.

70. 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

71. 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.

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

REFERRAL TO THE NCAS

73. 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.

74. 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.

75. 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.

76. 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.

77. 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.

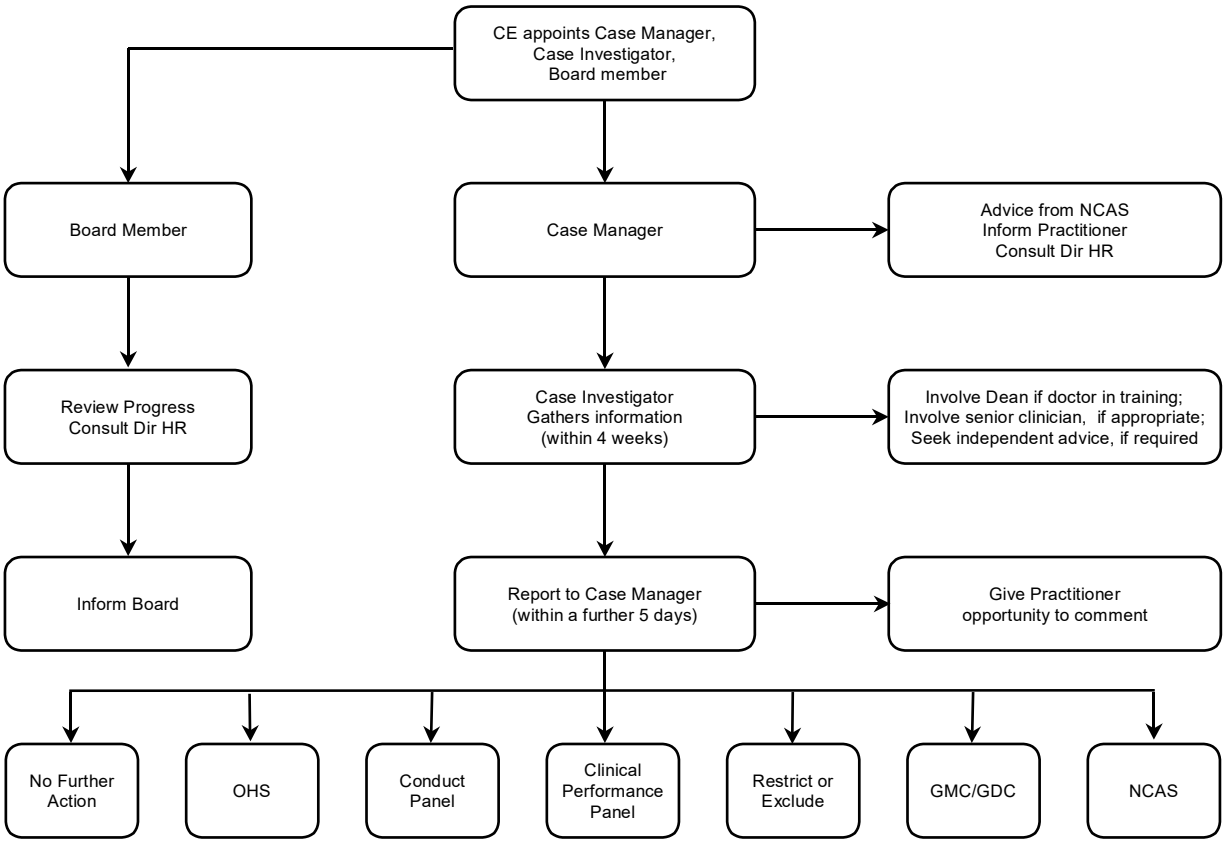
78. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HSC or private sector other than their main place of HSC employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals in its Handbook. 8. See also circular HSS (TC8) 5/04.

79. 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.

80. 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.

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

FORMAL PROCESS



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
   (iii) Investigation
   (iv) Options Following Investigation
   (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 situation may warrant this approach.

Purpose and Coverage of 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 framework 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.

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

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.

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

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.

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.

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

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

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.

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

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

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.

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 with standards set by the GDC. External verifiers will be established and they

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

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. However, all HSC organisations are required to ensure that they have a *Whistle Blowing* policy 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

8 [redacted]
irrelevant redacted by the USI

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 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

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

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

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.

38 Good practice in carrying out investigations of concerns can be summerised in the following principles, [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 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

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.

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

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.

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

[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

- ***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

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.

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.

45 If any case is to proceed, evidence has to be demonstrated. 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

46 The investigatory process should commence with a preliminary investigation to establish the facts 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.

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

Commented [JL5]: Check organisational processes

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

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

- Review of relevant clinical or administrative records

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

- Review of any report or documentation relating to the concern. If 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

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 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

52 Where it has been established decided that an extended investigation should 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

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.

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

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

56 The Board of the organisation, through the Chief Executive, has responsibility for ensuring that this process 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, information provided to them should only be sufficient to assure that this process is being followed. The exception to this will be for the *designated Board member* whose role is to:

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

57 The role of other key individuals in an extended investigation are defines in the Glossary in this framework.

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.

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 [JL9]: Define accompanied in this instance

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.

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

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.

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.

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.

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.

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.

67 A written record must be maintained during 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 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.

[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.

TIMESCALES AND DECISION MAKING

70 The CI should, other than in exceptional circumstances, aim to complete the investigation within 4 weeks of appointment and submit their report to the CM within a further 5 working days. The CM must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the CI.

71 Comments in writing from the practitioner, including any mitigation, must normally be submitted to the CM 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.

72 The CI's report should give the CM 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

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.

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 [JL10]: Does this refer to resignation?

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.

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.

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

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

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.

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.

SECTION 4 OPTIONS FOLLOWING INVESTIGATION

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

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 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.

Commented [JL11]: Which individuals?

OPTIONS FOLLOWING PRELIMINARY INVESTIGATION

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 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.

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 [JL12]: 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. The practitioner should be informed of this decision as soon as possible and the record of the investigation completed. This should 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.

Commented [JL13]: Need HR Input

REMEDIAL ACTION REQUIRED

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.

MEASURES TO ENSURE PATIENT SAFETY

RESTRICTIONS ON PRACTICE

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

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

89 The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving

Commented [RH14]: ? is this a preliminary investigation

the clinical manager, the Medical Director/Responsible Officer and appropriate representation from Human Resources.

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

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

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

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

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

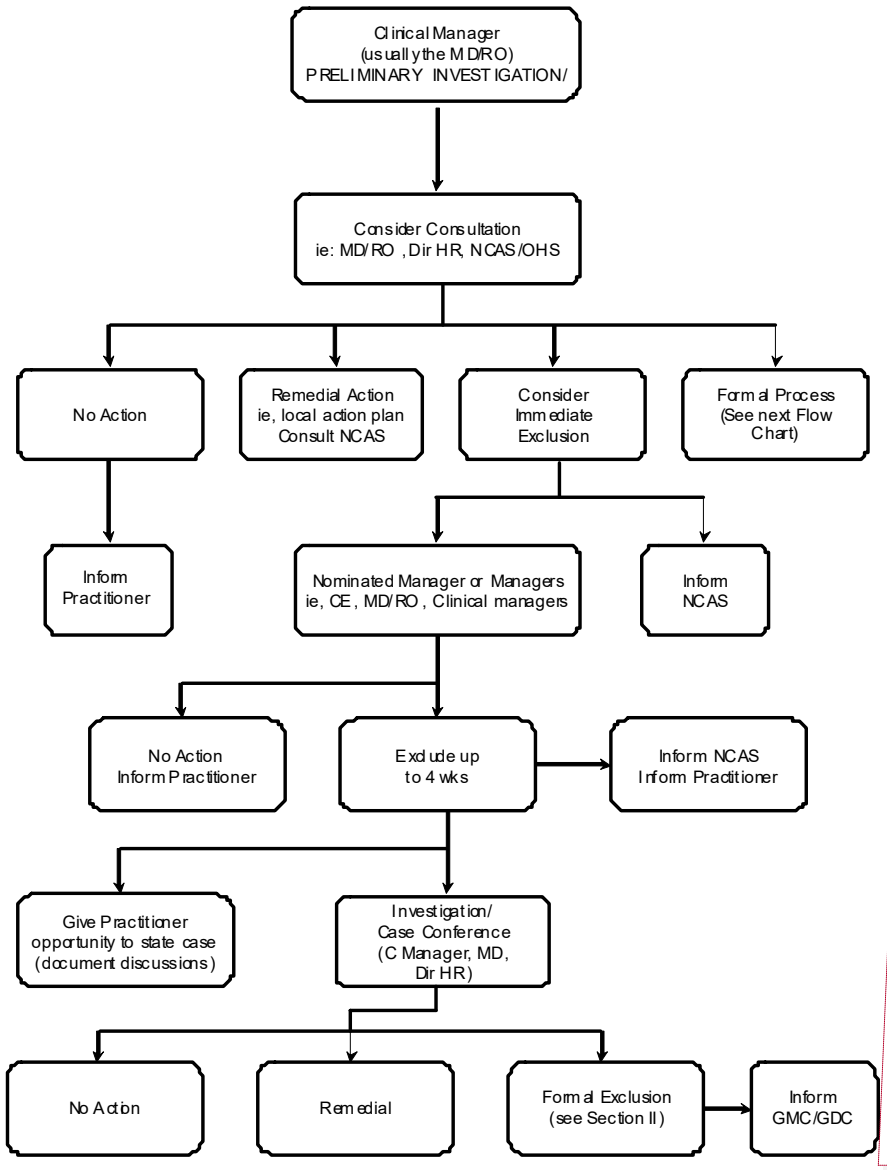
Commented [JL15]: Define immediate and formal at beginning of section.

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.

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.

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

INFORMAL PROCESS



Commented [JL16]: Remove/revise

OPTIONS FOLLOWING EXTENDED INVESTIGATION.

98 Options following an extended investigation are described in this section. As with 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

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

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.

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.

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.

Commented [JL17]: Rephrase?

HANDLING HEALTH ISSUES

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 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.

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.

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.

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

Commented [JL18]: Check original version-what does this refer to?

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

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.

108 Examples of action to take:

- sickness absence for the practitioner (the practitioner should be contacted frequently to ensure they receive any support they may require);
- 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)

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.

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.

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.

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.

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

Commented [JL19]: ? Remove para

HANDLING OF ILLNESS ARISING DURING EXTENDED INVESTIGATION

114 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.

115 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.

116 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.

Roberts, Naomi

From: Lindsay, Jane
Sent: 13 February 2012 09:25
To: Woods, Paddy; Kilgallen, Anne; Roberts, Margot; Reid, Simon; O'Carolan, Donncha; mervyn.barkley Personal Information redacted by the USI
Cc: Hutchison, Ruth
Subject: Meeting Note MHPS Working Group

Colleagues

Please find attached a note of our MHPS Working Group meeting held on 8th February 2012 .

Kind Regards

Jane

Jane Lindsay
Programme 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

Meeting of MHPS Working Group ...

Roberts, Naomi

From: Roberts, Margot
Sent: 14 February 2012 09:41
To: Lindsay, Jane; Woods, Paddy; Kilgallen, Anne; Reid, Simon; O'Carolan, Donncha; mervyn.barkley [redacted]
Cc: Hutchison, Ruth
Subject: RE: Meeting Note MHPS Working Group

Paddy

As promised I've attached the Memorandum of Understanding between the GMC and COPMeD. Para 14 refers.

_GMC_COPMeDM
(2) (2).pdf

Margot

Margot Roberts
Administrative Director
Northern Ireland Medical and Dental Training Agency
Beechill House
42 Beechill Road
Belfast BT8 7RL

Tel: [redacted]
www.nimdta.gov.uk
[redacted]

From: Lindsay, Jane
Sent: 13 February 2012 09:25
To: Woods, Paddy; Kilgallen, Anne; Roberts, Margot; Reid, Simon; O'Carolan, Donncha; mervyn.barkley [redacted]
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Jane Lindsay
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DHSSPS,
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Belfast BT4 3SQ
[redacted] **Mobile** [redacted]

<< File: Meeting of MHPS Working Group 080212.DOC >>

Memorandum of Understanding between the General Medical Council (GMC) and the Conference of Post Graduate Medical Deaneries (COPMeD)

April 2007

Purpose

1. The purpose of this Memorandum of Understanding is to set out a framework between COPMeD and the GMC to facilitate effective liaison between the GMC and constituent Postgraduate Deaneries in relation to individual doctors and areas of mutual interest.

2. This Memorandum covers the main interfaces between Postgraduate Deans and the GMC, clarifies respective roles and responsibilities and outlines the mechanisms in place to promote effective working. This agreement does not affect existing statutory functions or amend any other policies or agreements relating to the activities of COPMeD or the GMC.

Functions of the GMC and COPMeD

GMC

3. The GMC is the statutory body responsible for regulating the medical profession in the United Kingdom. Its purpose is to

> *'Protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine.'*

4. The GMC has statutory powers under the Medical Act 1983 to take action on a doctor's registration when concerns are raised which call their fitness to practise into question.

5. The GMC is not a general complaints body and can act only where there is evidence that a doctor's fitness to practise may be impaired. Lesser problems can usually be resolved locally, for example through the NHS procedures. A memorandum of understanding is in place between the GMC and the National Clinical Assessment Service (part of the National Patient Safety Agency) to encourage effective co-operation.

6. Further details on the GMC's remit can be found at Annex A.

COPMED

7. COPMeD is the Conference of Postgraduate Medical Deans. Postgraduate Deans manage the postgraduate training of doctors, and the continuing professional development of GPs.

8. COPMeD provides a forum in which members can meet to discuss current issues, share best practice and agree a consistent and equitable approach to training in all Deaneries. It acts as a focal point for contact between the Postgraduate Medical Deans and other organisations, e.g. Medical Royal Colleges, GMC, BMA, MRC, AMRC and NHS Executive.

9. Postgraduate Deans are responsible for organising remedial training for those doctors employed in the categories above. They are also well-placed to provide career advice for doctors who are currently not employed.

Collaborative working arrangements

10. Collaborative working between the organisations falls into two strands:

Referral of doctors between the GMC and Postgraduate Deans

Communication and liaison mechanisms.

Referral of doctors between the GMC and Deaneries

11. Doctors may be referred by the GMC to the Postgraduate Dean following an investigation, which may have included an assessment of the doctor's health and/or performance, and following which the doctor is found to have impaired fitness to practise. In practice these referrals will be contained either in undertakings agreed between the GMC and the doctor, or in determinations of Fitness to Practise panels.

12. Whilst the GMC defines the policy framework within which Fitness to Practise panels operate the panels are independent of the GMC in relation to individual cases. The GMC will take all practical steps to ensure that the referral conforms to agreed protocols and does not impose obligations on Deaneries outside the remit specified within this memorandum. The GMC will also ensure that all doctors referred to a Postgraduate Dean are informed in writing that the Deanery is under no obligation to locate employment or fund training courses for them.

13. On receipt of the referral, for doctors who are currently in a training programme of the relevant Deanery, the Postgraduate Deanery will:

- plan targeted or remedial training following local performance procedures, RITA panel outcomes, or GMC or NCAS performance assessment
- where appropriate, identify an alternative training placement or placements suitable to meet the needs of the trainee
- dentify a named clinical and educational supervisor
- agree arrangements for monitoring performance against objectives in action plans, either locally or at Deanery level
- advise on provision of mentoring and coaching when required
- provide access to confidential psychological support
- report to the GMC at regular, agreed intervals on the progress of the doctor

14. For doctors who are not appointed to, or substantively employed in, a Deanery training programme, or at all, the Deanery will see doctors referred by the GMC who live or work in their catchment area, and will:

- help the referred doctor to develop a personal development plan to address identified weaknesses in performance
- agree a means and timescale for monitoring that the objectives in the plan have been carried out
- offer information with regard to career opportunities
- explain how to access training placements through open competition
- offer guidance with respect to preparing a CV and covering letter for potential employers
- identify sources of appropriate educational supervision, coaching or mentorship
- organise where appropriate and practicable, an unpaid clinical attachment (observership) with a consultant who will be asked to provide a report
- provide a report to the GMC relating to the extent to which the doctor has cooperated with and benefited from the above

15. Doctors may be referred to the GMC by the Postgraduate Dean where the Dean has developed concerns that the doctor's fitness to practise may be seriously impaired. In such cases it will often be appropriate to discuss the referral prior to making it. Where this discussion takes place the GMC will advise the Dean on potential referrals to the GMC, and agree responsibilities for actions in individual cases. These discussions should normally take place between those listed at Annex B.

16. Where the Dean does make a referral the GMC will:

- investigate the fitness to practise of the doctor
- where appropriate, assess the doctor's performance and/or health through fitness to practise procedures
- make decisions as to whether the doctor's fitness to practise is impaired, and if so

apply proportionate restrictions to their registration

send a copy of any performance assessment report, and of any restrictions imposed on the doctor's registration, to the Deanery

monitor compliance with any restrictions, and take appropriate action

communicate regularly with the Deanery throughout the period of restriction

Communication and liaison mechanisms

17. Both bodies are committed to effective communication at whatever level is most effective for the circumstances. Areas of communication between the GMC and Postgraduate Deans outside the referrals described above include:

Informal discussion of appropriate response to emerging problems with individual doctors

Discussion on individual doctors already referred

Other areas of communication

Informal discussion of appropriate response to emerging problems with individual doctors

18. Either body may need to contact the other to discuss what action it is appropriate to take on concerns about individual doctors. Normally, these contacts will be through the people identified in Annex B, but that list is not exclusive. If the GMC is satisfied that sufficient action is being taken locally, either by the employer or the Postgraduate Dean, to protect the public, then it will not take formal action though it will maintain a record of the exchange. If at any point the GMC believes that the actions of a doctor may be putting the public at risk, it will initiate formal action. Where the outcome of informal discussion is a proposal for action by the Postgraduate Dean the GMC may ask for a report later from the Dean in order to decide whether formal GMC action is required.

19. If a Postgraduate Dean wishes to check whether the GMC is investigating or has taken action against, a specific doctor they will contact the GMC. The GMC will normally disclose information about current cases against a doctor which have proceeded to or beyond the stages at which it is required to notify the doctor's employers.

Discussion on individual doctors already referred

20. Each doctor that has been referred between the Postgraduate Dean and the GMC will have a named investigation officer based within the Fitness to Practise directorate at the GMC who is responsible for managing the case, and a named member of staff at the relevant Deanery. Communication concerning these doctors will normally be between these staff members at the Deanery and the GMC, however may also take place between those identified in Annex B where appropriate.

Other areas of communication

21. The GMC and COPMeD will share information about trends, concerns, data, approaches and initiatives, which are relevant to improving the quality of patient care.

22. The GMC and COPMeD will take a collaborative approach to educating employers, commissioners and medical staff about fitness to practise issues.

23. The GMC and COPMeD will invite contributions from each other to policy and operational guidance, reports and other mechanisms, as appropriate, in order to ensure factual accuracy, to benefit from each other's knowledge and expertise, and to promote consistency of advice.

24. The GMC and COPMeD will assist each other, as appropriate, in providing information for investigations and initiatives to promote the objectives of the two organisations.

Privacy provisions

25. It is agreed that statutory and other constraints on the exchange of information will

be fully respected.

26. Under Section 35B(2) of the Medical Act 1983, as amended, the GMC may disclose to any person any information relating to a practitioner's fitness to practise which the GMC considers to be in the public interest to disclose. The GMC's policy intent is to disclose such information to COPMeD when the GMC considers it to be in the public interest. Each organisation will respect and, as appropriate, take steps to protect the confidential nature of information that the other may provide.

27. The GMC is subject to the general disclosure provisions of the Freedom of Information Act 2000 (FOI), and as such may be required to disclose information to a third party which COPMeD has provided to the GMC. If this occurs the GMC will discuss the FOI request with COPMeD to ascertain whether the request may be exempt from the FOI disclosure provisions.

Reconciliation of disagreement

28. Any disagreements will normally be resolved amicably at working level. If this is not possible, the contact points listed at Annex B will seek to settle the issue and ensure a mutually satisfactory resolution. Senior management of both parties will be involved as necessary.

Review of Memorandum of Understanding

29. This Memorandum will be reviewed annually and if necessary following any pertinent changes to policies, procedures and structures of the parties concerned.

Signed: ..... Date:
Mr Finlay Scott
Chief Executive, General Medical Council

Signed: ..... Date:
Professor Elisabeth Paice
Chair, Conference of Post Graduate Medical Deaneries

Annex A

The GMC is the regulator of the medical profession. It is a charity (registration number 1089278), and its purpose is to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine. It is also a statutory body and its core functions are defined by statute (the Medical Act 1983, as amended).The governing body, the Council, has 35 members:

19 doctors elected by the doctors on the register

14 members of the public appointed by the Privy Council

2 academics appointed by educational bodies - the universities and medical royal colleges.

The Privy Council nominees are not medically qualified. Their task is to speak for the public, act as a focus for debate between doctors and patients and play a vital part in all areas of our work.

Functions

The GMC is required by law to:

keep up to date registers of qualified doctors
foster good medical practice
promote high standards of medical education
deal firmly and fairly with doctors whose fitness to practise is in doubt

Registration

Maintaining the medical register is at the heart of the GMC's work. The register shows who is properly qualified to practise medicine and lists over 200,000 doctors. It is held on computer and updated every day as doctors move, gain new qualifications, change jobs, retire or are registered by the GMC for the first time. No doctor can practise medicine in the UK if he or she is not registered; and to be registered they must have a recognised medical qualification.

The GMC publishes a specialist register, showing the doctors who have completed specialist training. Doctors must be included in this to be eligible for most substantive or honorary consultant posts in the NHS.

Good Medical Practice

Registration carries both privileges and responsibilities. The GMC summarise these responsibilities in key principles, which it calls the duties of a doctor - the contract between doctor and patient which is at the heart of medicine.
The GMC builds on these principles in guidance covering both general aspects of good medical practice and more specific areas, such as confidentiality and consent. This guidance describes the principles of good medical practice and standards of competence, care and conduct expected of doctors in all aspects of their professional work. Serious or persistent failures to meet these standards may put a doctor's registration at risk.

Medical education

Registration requires high standards of medical education; and the GMC has general responsibilities to promote high standards in and to co-ordinate all stages of medical education. It has varying specific responsibilities for education and training throughout a doctor's career. For example, it ensures that doctors who become registered have the knowledge, skills and attitudes that they will need to maintain a good standard of practice and care.

Fitness to practise

The GMC has strong and effective legal powers to maintain the standards the public have a right to expect of doctors. It is not a general complaints body and can act only where there is evidence that a doctor may not be fit to practise. It can take action if a doctor's fitness to practise is impaired. This may be for a number of reasons:

misconduct;

deficient performance;

a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales);
physical or mental ill-health;

a determination (decision) by a regulatory body either in the British Isles or overseas.

Action can range from issuing a warning to - in the most serious cases - erasing the doctor from the register, with a range of options in between.

Annex B

Contacts:

GMC

Paul Philip, Director of Fitness to Practise, Personal Information redacted by the USI
Blake Dobson, Head of Case Review, Personal Information redacted by the USI
Jackie Smith, Head of Investigations, Personal Information redacted by the USI

COPMED

Professor Elisabeth Paice, Post Graduate Dean Director, London & Chair of COPMeD
Postgraduate deans (or their Nominated deputy), from each Deanery in the UK

Roberts, Naomi

From: Lindsay, Jane
Sent: 31 May 2012 09:18
To: mervyn.barkley [redacted]; Kilgallen, Anne; Roberts, Margot; Reid, Simon; Paddy.Woods [redacted]
Cc: Martyn, Charlie; O'Carolan, Donncha; Hutchison, Ruth; Simpson, John
Subject: Revision of MHPS

Dear Colleagues,

The next meeting of our MHPS working group will take place on **Monday 11th June at 2pm** in Dr Woods' office.

I have attached two recent publications for your consideration, one from the NHS Revalidation Support Team (link below) and the other from NHS Employers that both describe processes for managing concerns. It would appear that DH are not intending to revise their version of MHPS but rather provide this supporting Guidance.

I have also attached guidance developed by the Southern Trust to support the use of MHPS in their organisational context that may be of interest.

Kind Regards

Jane

NHS Employers Guidance on Ma...

SHSCT - Trust Guideline for Ha...

[redacted]

Jane Lindsay
Programme Manager-Confidence in Care
DHSSPS,
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Staying on course - supporting doctors in difficulty through early and effective action

April 2012

Introduction

This document is not intended to be a comprehensive "how to" manual. Instead, its purpose is to encourage the adoption of a culture of early identification and intervention.

It is aimed at those responsible for managing the performance of medical staff, including responsible officers, medical directors, clinical managers, and human resources professionals.

The focus of the guidance is primarily on employed doctors working in managed settings. The general principles and approaches outlined here are also relevant to other settings in which doctors work, including general practice.

NHS bodies with responsibility for commissioning services may also find this approach helpful in addressing concerns about the work of doctors in general practice in the NHS, independent or voluntary sector.

What this guidance seeks to do

This guidance highlights the importance of early intervention when concerns first arise about an individual doctor. Early intervention:

- can minimise any risk to patients and other staff
- ensures that steps are taken to return the doctor to safe and effective practice
- helps avoid more formal disciplinary or regulatory action
- establishes the initial handling of concerns at work as an employment matter in which medical and HR professionals need to work closely together, rather than a regulatory matter.

If it is not possible to resolve the concern at an early stage then further and more formal action will be required through local conduct, health and capability procedures and/or through the fitness to practise processes of the General Medical Council (GMC). The guidance reflects the principles of good practice covering all healthcare professionals set out in the Department of Health and NCAS guidance *Handling concerns about the performance of healthcare professionals*. Responsible officers (ROs) now have a responsibility to establish and implement procedures to deal with questions concerning a doctor’s fitness to practise.

In the case of clinical academics, there needs to be clarity on their relationship to the NHS employer and the involvement of the university employer where this is relevant and appropriate. NHS bodies should jointly prepare a formal agreement on procedures for staff with academic and clinical duties for the management of poor performance and disciplinary procedures. These procedures should:

- ensure joint working from the time of implementation
- specify which body is to take the lead in different types of case
- ensure suitable cross-membership of any panels
- work quickly and effectively.

The Follett Report contains a number of key recommendations aimed at promoting joint working to integrate separate responsibilities between university and NHS bodies in respect of employment practices for staff with academic and clinical duties.

Before concerns arise

The vast majority of doctors provide good quality, safe and effective care throughout their careers. However, it is inevitable that from time to time problems will arise. Systems failure or organisational issues can impact significantly on performance and give rise to concerns. Organisations should have in place measures to help reduce the risk of problems arising in the first place and, when they do, to identify them at an early stage. Such measures should include:

- strong medical leadership
- strong human resource leadership
- effective recruitment procedures
- effective induction processes that cover the raising of concerns and how they are managed
- robust annual appraisal and personal development planning
- mentorship
- promotion of self-referral schemes
- clear written policies and procedures for dealing with concerns that are internally publicised and reviewed at regular intervals
- training for managers and staff whose responsibility it is to lead on the management of concerns
- robust clinical governance arrangements, including reporting and acting on concerns and complaints.

Principles for handling concerns at work

The principles and values of the GMCs *Good Medical Practice* apply in which

- patient safety is paramount

- concerns about a doctor's practice must be addressed early, systematically and pro-actively in all health care settings. The appropriate competent authority (as defined in the responsible officer regulations) must take action where a concern is raised.

Putting patients first

Patient safety must be the primary consideration, although processes should ensure fairness to doctors, their health and wellbeing and the interests of others affected by performance concerns.

Everyone involved in healthcare is obliged to share concerns about performance of colleagues and themselves, for the purposes of patient safety and for the protection of the public and colleagues. This helps maintain the quality and reputation of services and protects the welfare of doctors and other workers. The GMC has issued guidance to doctors on:

- raising concerns, which gives advice on raising a concern that patients might be at the risk of harm
- acting on concerns, which explains doctors responsibilities when colleagues or others raise concerns with them, and how those concerns should be handled.

Advice about sharing concerns at work is also available through NHS Employers and other organisations such as the National Clinical Assessment Service (NCAS).

In most cases, concerns should be managed locally using processes that are locally determined, but consistent with national Directions and Regulations, and assured by the responsible officer. Organisations should ensure that their managers and staff are familiar with and adequately trained on these processes and are able to use them appropriately and effectively. Failure to follow agreed procedures can lead to disputes and legal challenges, which have the potential to detract from the overriding aims of safeguarding patient safety and providing high quality services.

Individually tailored solutions provided by external organisations may be required from time to time. For example, competency advice and assistance may come from the medical Royal Colleges, and NCAS offers a range of support to employing and commissioning organisations. For doctors in training, postgraduate deaneries need to ensure that assessment processes allow for concerns arising during training to be addressed.

There should be equity of access to support, process, time and effort. Timescales should be set and adhered to and should be broadly similar for all. Those timescales should also be relatively short – the more time taken to deal with concerns the less

likely they will be dealt with effectively. In the event that a timescale cannot be met this should be communicated at an early stage and a revised timescale set.

Formal or informal action?

Cases involving minor misconduct or early indications of unsatisfactory performance may be handled informally. For example, additional training, coaching or advice may resolve the concern. If informal action does not bring about sufficient improvement, or if the matter is considered too serious to be classed as minor, then employers should make it clear that formal action will be necessary.

Informal resolution should ideally be a two-way discussion of those aspects of performance or conduct which are causing concern and suggesting ways of sustained improvement. Where improvement is required, the employer needs to make it clear to the employee what needs to be done, over what timescale and how their performance or conduct will be reviewed. The employer should keep notes of any agreed informal action and consider sharing these with the employee. This ensures that informal action is more than a just a passing comment or casual aside and is designed to achieve an agreed outcome.

Employers should take care that informal action does not turn, without notice to the doctor, into formal disciplinary action as this may inadvertently deprive the doctor of certain rights under the formal procedure (such as the right to be accompanied). If, during an informal discussion it becomes clear that the matter may be more serious, then the meeting should be adjourned and the employee should be told that the matter will be continued under formal procedures.

Any concern about the capability or conduct of a doctor in training should initially be considered as a training issue and the involvement of the postgraduate dean should be sought. Deaneries must be informed of any concerns and actions taken to allow the dean to carry out his or her role as responsible officer.

Handling concerns at work is routine

Employers and contractors are responsible for ensuring that appraisals take place and that a personal development plan is agreed. They should also manage remediation locally, wherever possible. The responsible officer will have a key role in managing remediation processes locally, assuring their quality and advising on the threshold at which a concern needs to be referred to the professional regulator. The GMC also has an employer liaison service to support ROs in their role around fitness to practise and revalidation.

Individual practitioners have a personal responsibility for their own health (including being registered with a GP), conduct and capability. In particular, they should ensure that they:

- work in accordance with *Good Medical Practice* and other relevant GMC guidance
- work within the relevant specialty framework
- meet any employment or contractual-related standards for their current role, including engaging in appraisal and personal development processes
- are honest about when they feel they might have competence and capability problems and seek early help and support
- engage constructively with their employer or contracting body when problems are identified and investigated.

Once a concern is raised, the organisation should carry out an initial investigation to determine the appropriate response:

- Health matters should be referred to occupational health or any relevant medical service.
- Conduct matters should be dealt with by the employer.
- Capability issues should be dealt with locally in the first instance.
- Regulatory matters should be referred to the regulatory body in parallel with local processes. The GMC employer liaison service is able to advise.
- Any criminal matters should be referred to the police in parallel with local and regulatory processes - acting in a linear way can increase the length of time it takes to resolve issues.
- Any cases of fraud should be referred to the Counter Fraud and Security Management Service for advice.

Remediation

There should be a consistent approach to providing remediation, locally delivered as far as possible, with active involvement, where appropriate, from external expert organisations. The following principles should apply:

- There should be a full evaluation of the nature of the concern so that appropriate action is taken according to relevant processes.
- The medical director and/or responsible officer and the human resource director should provide joint leadership.
- The investigation should follow an agreed process and should also assess whether there are any organisational issues that need to be addressed.
- There should be comprehensive documentation and record-keeping throughout the process.
- There should be an assessment of the need to keep patients to date, recognising confidentiality of the individual concerned.
- Doctors requiring remediation must understand what they need to achieve, the timescale and the methods involved so that they will be able to

demonstrate that they have successfully completed the programme. They also need to understand the cause of the concern - insight can contribute to a successful outcome.
- There should be a clear, jointly-agreed strategy on how the remediation process should end.
- Confidentiality should be maintained as far as it is practicable to do so.
- Where concerns arise about a newly appointed doctor or a doctor who has recently completed training, the medical director/responsible officer should liaise with the relevant postgraduate dean to ensure that there are no systemic failures in the deanery selection and assessment process.

Defining and categorising concerns

Concerns at work fall into three main categories:

- health
- conduct
- capability

However, concerns can vary in scale and complexity. In some cases what appears to be a capability issue may reflect underlying health problems. A conduct case may involve elements of professional misconduct. Early identification of the problems underlying the concern will help in determining the most effective course of action.

What emerges from each of these processes can also vary widely. In each area, one of the potential outcomes could be to enter a local remediation process aimed at reducing the risk of the doctor having restrictions placed on their registration by the regulator, or of losing their employment.

The aim of tackling concerns early is to ensure the doctor remains in, or returns to, full and unsupported medical practice as quickly as possible. Where this is not possible, more formal processes should be followed. This may trigger support from other agencies such as the relevant medical Royal College, NCAS or the local deanery.

Handling concerns due to health

It is important to intervene early and effectively to support colleagues who are suffering from ill health where this is impacting on their work through their absence, or through restrictions on the amount and quality of their work. In such cases, occupational health advice should be taken and local health and wellbeing procedures need to be followed.

Local human resource departments should be able to advise on what should be done and how it should be done. The earlier they are involved the better. Clinical

managers, responsible officers and medical directors should work closely with HR colleagues to ensure that the right intervention is made at the right time.

The importance of early intervention is emphasised by the statistic that once a colleague has been absent for over six weeks, there is a 50 per cent chance they will not return to work. This demonstrates the need for swift diagnosis and likely prognosis, and agreeing support to help employees get back to work using such things as phased returns, support from occupational health departments and adjustments to duties.

The 2011 annual report of the NHS Practitioner Health Programme shows that effective intervention leads to:

- improvements in mental health and social functioning
- increased numbers returning to work and/or training
- a reduction in potential risk to practitioners and the public
- a reduction in regulatory involvement or changes to fitness to practise conditions
- financial benefits to the service.

Handling concerns due to conduct

Conduct issues may be causing concerns at work and these should also be dealt with locally under agreed local procedures and codes of conduct. In cases where the concerns are more serious or are likely to impact on patient safety, it may be necessary to involve the regulator. Medical managers should seek the advice and support of their HR department to identify early and effective interventions that resolve the issues of concern.

Conduct is typically dealt with under the provisions of locally-agreed procedures. These are often based on the best practices reflected in the ACAS Code of Practice on disciplinary and grievance procedures. The key principle is that such procedures are not about penalising staff but are about improving behaviour and performance for the benefit of the individual, their colleagues, their patients, and their organisations.

The ACAS statutory code on disciplinary procedures was introduced in 2009, on a principles-based good practice approach rather than on a detailed and prescriptive procedural requirement. The code aims to encourage resolution of concerns at work earlier through informal means without recourse to formal procedures. It aims to encourage early and effective interventions. This is essential to effective work on conduct concerns so that, where possible, they are resolved swiftly long before careers and livelihoods are at risk of being lost.

Every concern about conduct should be considered at the earliest opportunity. In the most extreme cases, such as allegations of assaulting a patient, this may mean exclusion from work according to the principles and timescales set out in *Maintaining High Professional Standards in the Modern NHS* . It is in the interests of the individual doctor, other staff, patients and the public that such processes are handled quickly and effectively.

In some cases, conduct matters may have a professional element that defines them as 'professional misconduct'. In these cases any formal action should take into account the provisions set out in part 3 of *Maintaining High Professional Standards in the Modern NHS*, covering the requirement for an external medical member of any disciplinary panel. NCAS is able to advise on the most appropriate procedure. The GMC's Employer Liaison Service can also advise on the need for any regulatory input.

Handling concerns due to capability

This type of concern often represents the most difficult area to deal with because judging the doctor's workload and the quality of a doctor's work inevitably involves a degree of subjectivity. It can also cover a wide range of things, from poor or inaccurate diagnoses to poor quality interventions and treatments.

Concerns about attitude, behaviour and communication can also arise in the conduct category, so an assessment needs to be made as to which part of the process should apply when a particular concern arises. Where these matters directly affect the four key domains of *Good Medical Practice* (GMC) then they should be managed as capability issues. Those domains are:

- knowledge skills and performance
- safety and quality
- communication, partnership and teamwork
- maintaining trust.

The earlier that capability concerns are identified, discussed and resolved the better. Interventions such as training, mentoring, shadowing and extra supervision can often be deployed quickly and the doctor can return to normal working. The aim should be to deal with alleged shortcomings at the very earliest opportunity. Where concerns are observed directly it can be relatively easy to intervene to demonstrate better approaches to the work there and then. Alternatively, other opportunities for reflective learning should be used.

The formal procedure for handling concerns about a doctor's capability, including whether and when to refer a doctor to NCAS for an assessment, is set out in part 4 of *Maintaining High Professional Standards in the Modern NHS* , which highlights the role of NCAS at various stages of the process. In cases where the concerns are

more serious or likely to impact upon patient safety, it will normally be necessary to involve the regulator as well. This should not prevent the continuation of local processes.

Checklist: what employers need to do

- Have policies in place which link to *Maintaining High Professional Standards in the Modern NHS* and the Performers List Regulations.
- Understand the policies and train key members of staff on their content.
- Understand what outcomes are possible.
- Follow policies carefully and maintain a clear record of the concern and how it has been handled.
- Determine the type of concern (for example, health, conduct or capability) at an early stage and ask questions - why has the work deteriorated or failed to improve? What is the cause of the behaviour?
- Consider any underlying systems or organisational problems.
- Consider the seriousness of the concern - is it open to informal resolution or is it a serious matter that requires action to be taken under formal processes.
- Understand the GMC's thresholds for referral.
- Be clear about expectations about required standards of attitude and behaviour.
- Be clear about the need to draw attention to concerns at work at the earliest opportunity. Concerns that present too late are more difficult to resolve to the benefit of patients and staff.
- Be clear that “off the record” informality between managers and doctors does not resolve concerns and often makes them more difficult to handle effectively. Off the record does not change behaviour or discharge responsibility.

References

1. *Handling concerns about the performance of healthcare professionals: principles of good practice*, Department of Health, October 2006

2 *Good Medical Practice*, General Medical Council, November 2006

3 *Raising and acting on concerns about patient safety*, General Medical Council, 2012

4. NHS Employers' guidance on raising concerns

5 *Ill health retirement and sickness absence management: new arrangements for the NHS*, NHS Employers, March 2008

6 *Handling concerns about a practitioner's health - a guide for managers*, NCAS, Jan 2011

7 *The Back on Track framework for further training; restoring practitioners to safe and valued practice*, NCAS, December 2010

8 Your Health Matters, a GMC web resource for doctors with health concerns

9 *NHS Practitioner Health Programme annual report*, PHP, 2012

10 *The ACAS code of practice on disciplinary and grievance procedures*, ACAS, 2009

11 *Maintaining High Professional Standards in the Modern NHS*, Department of Health, 2005

12 *The Follett Report - a review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties*, Department for Education and Skills, September 2001

Southern Health and Social Care Trust

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance

Updated October 2017

INTRODUCTION

1.1 **Maintaining High Professional Standards in the Modern HPSS:** ***A framework for the handling of concerns about doctors and dentists in the HPSS*** (hereafter referred to as (MHPS)) was issued by the then Department of Health, Social Services and Public Safety (DHSSPS) in November 2005. MHPS provides the legally binding framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist and any subsequent action including restriction of practice or suspension (known in MHPS as exclusion).

1.2 This guidance document seeks to underpin the principle within MHPS that the management of performance is a continuous process to ensure both quality of service and to protect clinicians and that remedial and supportive action can be quickly taken before problems become serious or patients harmed.

1.3 MHPS is in six sections and covers:

I. Action when a concern first arises
II. Restriction of practice and exclusion from work
III. Conduct hearings and disciplinary procedures
IV. Procedures for dealing with issues of clinical performance
V. Handling concerns about a practitioner's health
VI. Formal procedures – general principles

1.4 MHPS states that each Trust must have in place procedures for handling concerns about an individual's performance which reflect the framework. This guidance, in accordance with MHPS, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about its doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response must be the same, i.e. to:

a) Ascertain quickly what has happened and why.
b) Determine whether there is a continuing risk.
c) Decide whether immediate action is needed to remove the source of the risk.
d) Establish actions to address any underlying problem. *MHPS Intro Para10*

1.5 This guidance also seeks to take account of the role of Responsible Officer and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems. Refer: Responsible Officer NI legislation

1.6 This guidance applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust. In accordance with MHPS, concerns about the performance of doctors and dentists in training will be handled in line with those for other medical and dental staff with the proviso that the Postgraduate Dean should be involved in appropriate cases from the outset.

1.7 This guidance should be read in conjunction with the following documents:
Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005
Annex B
"How to conduct a local performance investigation" NCAS, 2010
Annex C
SHSCT Disciplinary Procedure
Annex D
SHSCT Bullying and harassment Procedure

2.0 WHAT IS A CONCERN?

2.1 The management of performance is a continuous process which is intended to identify problems early to ensure corrective action can be taken. Everyone has a responsibility to raise concerns to ensure patient safety and wellbeing. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which do not necessarily require formal investigation or resort to disciplinary procedures.

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

MHPS Section1 para 2

- *Concerns expressed by other HPSS (HSC) 1staff*
- *Review of performance against job plans and annual appraisal*
- *Monitoring of data on clinical performance and quality of care*
- *Clinical governance, clinical audit and other quality improvement activities,*
- *Complaints about care by patients or relatives of patients*
- *Information from the regulatory bodies*
- *Litigation following allegations of negligence*
- *Information from the police or coroner*
- *Court judgements or*
- *Following the report of one or more critical clinical incidents or near misses*

- Failure to report concerns

2.3 Concerns can also come to light where a member of staff raises a complaint in relation to poor behaviour they find threatening, humiliating, unwanted, unwelcome or unpleasant. In line with the Trust's Working Well Together and Harassment at Work procedure, harassment can represent a single, serious incident or persistent abuse.

2.4 If it becomes evident that an individual or individuals were aware of a concern(s) but did not escalate or report it appropriately – this in itself can also represent a concern, which may necessitate intervention, particularly where there are patient safety implications.

2.5 WHO TO TELL?

2.5.1 A concern of any kind should be raised with the practitioner's immediate Clinical Manager. This will normally be the doctor's supervising consultant e.g:

Concerns relates to	**Clinical Manager**
Junior Doctor/SAS Doctor:	Supervising Consultant
Consultant	Clinical Director
Clinical Director	Associate Medical Director
Associate Medical Director	Medical Director

2.6 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) (the NCAS guide) indicates that regardless of how a concern is identified, it should go through a screening process to identify whether an investigation in needed. The NCAS Guide also indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

3.0 SCREENING PROCESS / *Preliminary Enquiries* ***MHPS Section1 para 15***

3.1 AS CLINICAL MANAGER - WHAT ACTION DO I TAKE?

3.1.1 If you receive a complaint or concerns are raised with you, the first step is to seek advice from the Medical Staffing Manager and have a "Screening of the Concern" to establish the immediate facts surrounding the complaint. This can include any documentary records such as timesheets/ written statements from the member of staff who raised concern and any other witnesses. At this stage, you are only seeking information that is **readily available**.

3.1.2 **Important:** There is **no** need at this stage to be inviting people to formalised investigative meetings as this would be part of any subsequent investigation process if needed. There may be certain circumstances however where an initial meeting will be necessary to establish facts and

provide an opportunity for the practitioner to hear the concerns and respond which can help determine what, if any action needs to be taken. In any event you will need to inform the practitioner who is the subject of the concerns, advising that you are making them aware of the complaint as part of this process. Do this sensitively and reconfirm that you are establishing the facts and no formal process has been entered into at this time. Assure the individual you will keep them informed and the matter will be progressed at pace.

3.1.3 The purpose of this stage is to gather enough information to enable the Clinical Manager, supported by a senior HR Manager (e.g. Medical Staffing Manager) to assess the seriousness of the concern/complaint raised and help inform and rationalise whether this needs to be resolved through a more formal route or informally.

3.1.4 It is important that the process is transparent. Early communication and discussion with the practitioner concerned, aimed at improving their performance or conduct may be sufficient to resolve the issue and identify early interventions to facilitate a resolution. The practitioner's early response can be helpful in deciding whether to carry out an investigation.

3.1.5 Contact with the practitioner who could potentially be subject to a formal investigation may not be appropriate if a counter fraud agency or the police advise early meetings or early disclosure could compromise subsequent investigations. The Director of HR will ensure there is close liaison with the CFPS and/or PSNI in such cases

3.1.6 In situations where a practitioner's ill health may be a significant contributory factor to their conduct or performance then appropriate advice should be sought from the Occupational Health Department.

3.2 DIFFERENCE BETWEEN SCREENING OF CONCERNS AND FORMAL INVESTIGATION

Screening / Establishing Facts (Informal)	Investigation (formal)
Clinical Manager gathering facts /information that has given rise to concern – readily available	Case Investigator – trained in MHPS and equality has been appointed by the Case Manager - this would not ordinarily be the supervising consultant.
Information readily available is gathered quickly, surrounding the concern/complaint	Investigation is directed by Terms of Reference established and agreed by Medical Director/Case Manager
The practitioner has been made aware	Individual would have been notified formally

informally that there is a concern	by Med Director /case manager that a formal investigation under MHPS is being commenced
Issue is managed locally with general advice from NCAS or Occupational Health if appropriate	Case has been formally logged with NCAS
No notice is required i.e. no invite to formal meeting	Right to notice to prepare following formal invite to a meeting in writing
Normally the initial meeting is between the manager and the individual concerned.	Right of representation applies
Progress is being managed locally with HR support	Progress is being monitored by a nominated NED – Case manager/ Medical Director and HR/CEO
No formal process to follow	Any action must be in line with MHPS /Trust disciplinary procedure for medical staff

3.3 SUPPORT FOR DOCTORS DURING SCREENING

Clinical Managers must consider the emotional wellbeing of individuals throughout this process and must not underestimate the impact this may have on a practitioner, so should be encouraged to seek assistance through the Occupational Health department and/or Care Call counselling services. The practitioner should be reminded that support is also available to them through their trade union representative and/or medical defence organisation.

3.4 WHAT HAPPENS AT THE END OF SCREENING PROCESS

The Clinical Manager and the nominated senior Human Resources Manager will be responsible for screening the concerns raised and assessing what action should be taken in response. In line with MHPS Section 1 para 15, this decision will be taken in consultation with the Medical Director, Director of HR and operational Director. Possible action could include:

3.4.1 Action in the event that reported concerns have no substantial basis or are completely refuted by other evidence.

No further action is required. The reasons for this decision should be documented and held by the responsible clinical manager.

3.4.2 **Action in the event that there are minor shortcomings** Minor shortcomings can initially be dealt with informally. The practitioner's Clinical Manager will be responsible for discussing the shortcomings with a view to identifying the causes and offering help to the practitioner to rectify them. Such counselling will not in itself represent part of the disciplinary procedures, although the fact and date that counselling was given, should be

recorded on a file note and retained on the practitioner's individual file.

3.4.3

3.4.4 A local action plan can be developed to address the issues with advice from NCAS if appropriate. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

3.4.5

In some cases, the Clinical Manager may feel it is appropriate to give an informal warning without a disciplinary investigation or hearing for the purposes of improving behaviour and in order to assist the practitioner to meet the standards required. The informal warning should be confirmed in writing to the practitioner. Advice must be sought from the Medical Staffing Manager. This is not a formal disciplinary sanction.

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

When potentially significant issues relating to performance are identified which may affect patient safety, the matter must be immediately escalated to the Associate Medical Director/Medical Director and Operational Director to consider whether it is necessary to consider 'Immediate Exclusion' from work (Refer to MHPS Section 1 para 18-27).

De[ending on the facts of a particular case, it may be necessary to place temporary restrictions on a practitioner's practice. Any voluntary agreement to restrictions should be recorded in writing including any undertaking to apply the same restrictions in any practice elsewhere (outside the Trust employment).

The Medical Staffing Manager must also be informed of any action taken to ensure the Chief Executive is notified and the correct procedures are followed including the necessity for NCAS to be informed prior to any immediate exclusion. (Reference Section 1 Para19 MHPS)

A Formal Investigation will usually be appropriate where the screening process identified information to suggest that the practitioner may pose a threat to patient safety, expose services to financial or other substantial risk, undermine the reputation or efficiency of services in some significant way or work outside acceptable practice guidelines and standards. (NCAS Good Practice Guide Section 1: pg. 7) In these situations, a thorough and robust investigation and report will help to clarify any action needed. Before the investigation proceeds, consideration will also be given to the appropriate protection and support that needs to be afforded to patients, those raising concerns, and the practitioner. (Refer to NCAS Good Practice Guide Section 2)

The Medical Director will then appoint a Case Manager, Case Investigator and Designated Board Member (on behalf of the Chief Executive). The Medical Director (which may be delegated to the Case Manager) should then draft the Terms of Reference for the formal investigation and the formal approach as set out in MHPS Section 1 para 28-41 will be followed.

During all stages of the process under MHPS - or subsequent disciplinary action under the Trust's disciplinary procedures – the practitioner may be accompanied to any interview or hearing by a companion. The companion may be a work colleague from the Trust, an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but not acting in a legal capacity. Refer MHPS Section 1 Para 30.

4.0 SUMMARY

4.1 The various processes involved in managing performance issues are described in a series of flowcharts / text in Appendices 1 to 7 of this document.

Appendix 1
Screening Process This can lead to resolution or move to:

Appendix 2
A formal investigation process. This can also lead to resolution or to:

Appendix 3
A conduct panel (under Trust's Disciplinary Procedure) OR a clinical performance panel depending on the nature of the issue

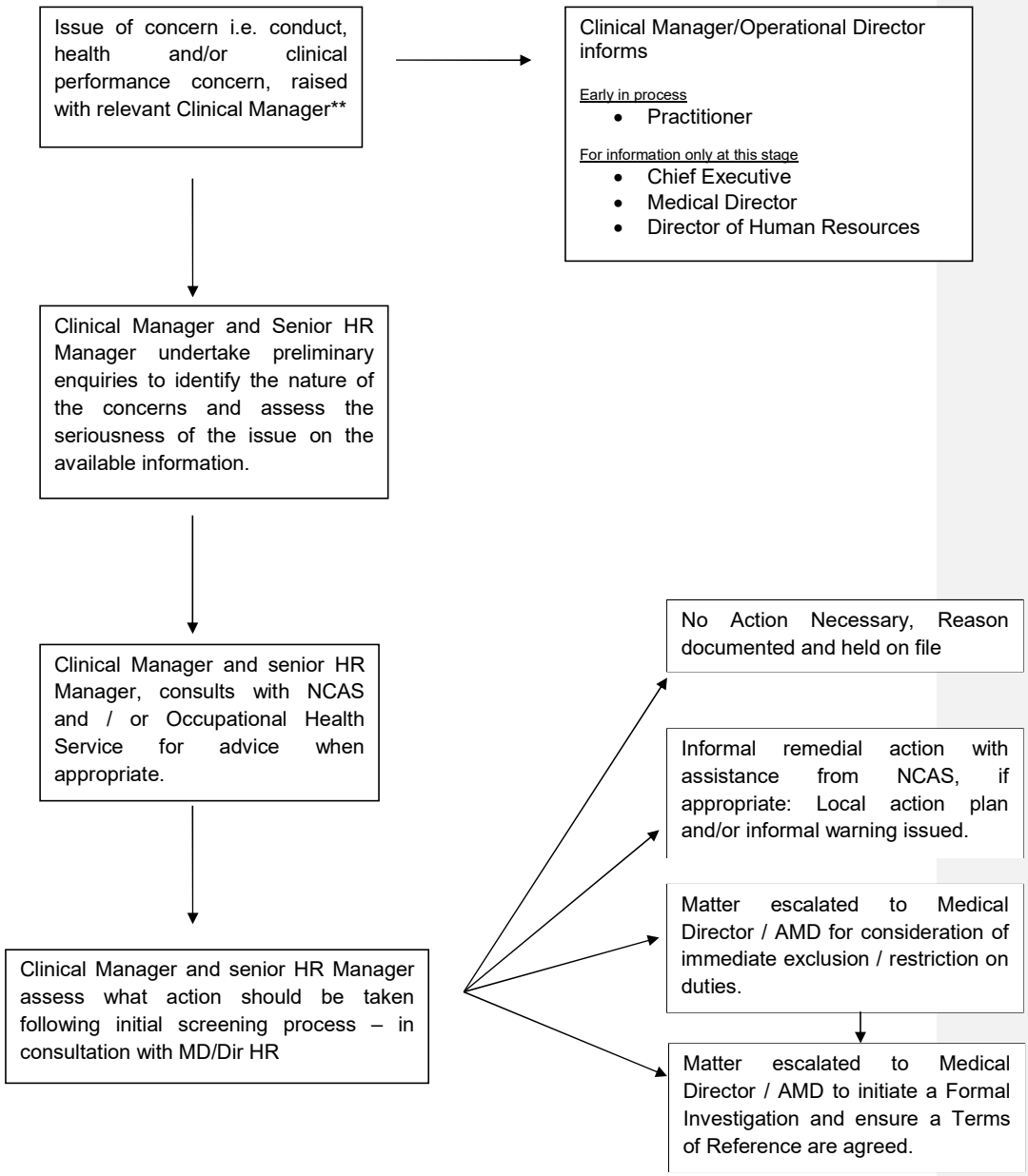
Appendix 4
An appeal panel can be invoked by the practitioner following a panel determination.

Appendix 5
Formal exclusion can be used in the context of a formal investigation

Appendix 6
Role definitions

Appendix 1

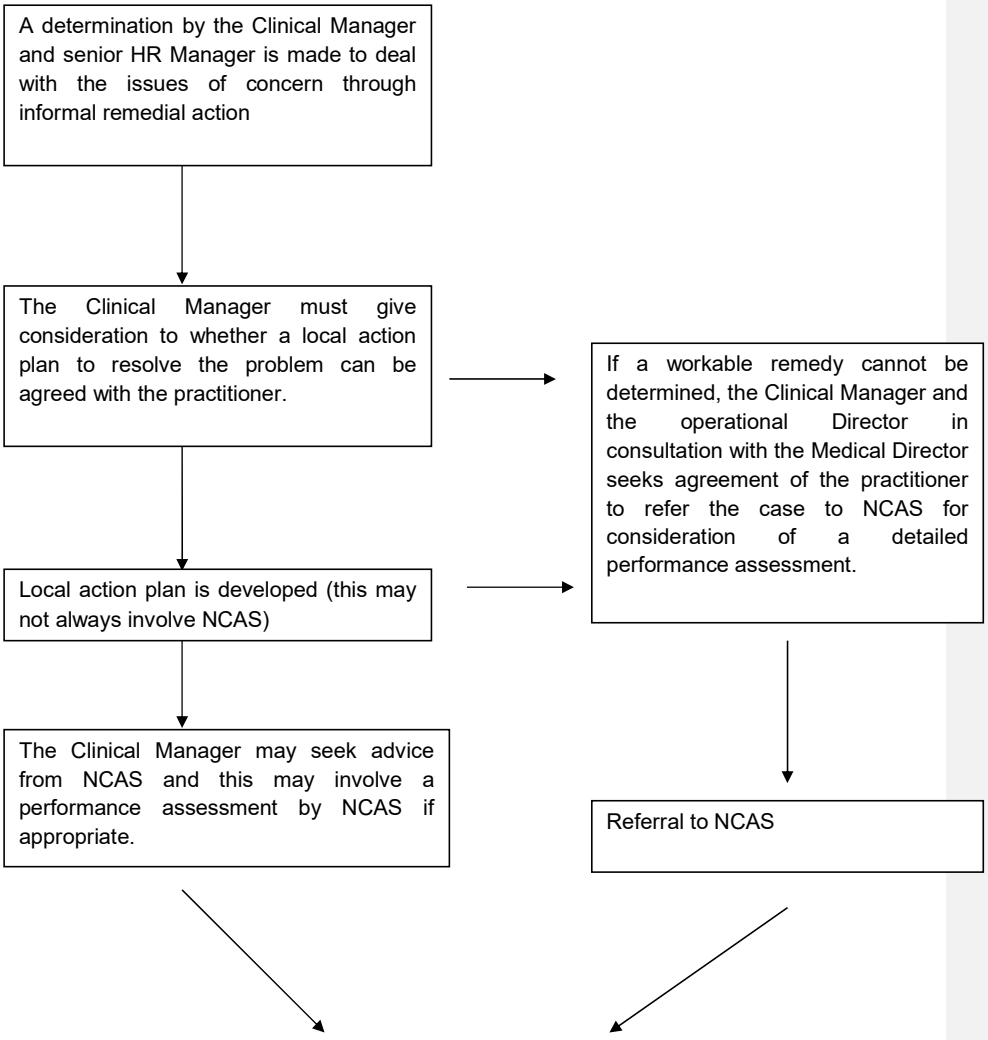
Step 1 Screening Process



** If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

Appendix 1

Informal Remedial Action



Appendix 2

Formal Investigation Process

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

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

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

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

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

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

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

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

Case Manager must then make a decision on whether:

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

Appendix 3

Outcome of Formal Investigation:
Conduct Hearings / Disciplinary Procedures

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

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

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

↓

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

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

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

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

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

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

Appendix 3a

Outcome of Formal Investigation:
Clinical Performance Hearings

Following the formal investigation, the Case Manager makes the decision that there is a clear failure by the Practitioner to deliver an acceptable standard of care or standard of clinical management, through lack of knowledge, ability or consistently poor performance i.e. a clinical performance issue.

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

↓

Case MUST be referred to the NCAS before consideration by a performance panel (unless the Practitioner refuses to have their case referred).

→ Following assessment by NCAS, if the Case Manager considers a Practitioner's practice so fundamentally flawed that no educational / organisational action plan is likely to be successful, the case should be referred to a clinical performance panel.

↓

Prior to the hearing the Case Manager must:
- Notify the Practitioner in writing of the decision to refer to a clinical performance panel at least 20 working days before the hearing.
- Notify the Practitioner of the allegations and the arrangements for proceeding
- Notify the Practitioner of the right to be accompanied
- Provide a copy of all relevant documentation/evidence

↓

Prior to the hearing:
- All parties must exchange documentation no later than 10 working days before the hearing.
- In the event of late evidence presented, consideration should be given to a new hearing date.
- Reasonably consider any request for postponement (refer to MHPS for time limits)
- Panel Chair must hear representations regarding any contested witness statement.
- A final list of witnesses agreed and shared between the parties not less than 2 working days in advance of the hearing.

↓

Composition of the panel – 3 people:
- **Chair -** Executive Director of the Trust (usually the Medical Director)
- **Panel 1 -** Member of Trust Board (usually the Operational Director)
- **Panel 2 -** Experienced medically / dentally qualified member not employed by the Trust

** for clinical academics including joint appointments a further panel member may be required.

→ Advisors to the Panel:
- a senior HR staff member
- an appropriately experienced clinician from the same or similar specialty but not employed by the Trust.

** a representative from a university if agreed in any protocol for joint appointments

Appendix 3a

Clinical Performance Hearings

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

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

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

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

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

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

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

Appendix 4

Appeal Procedures in Clinical Performance Cases

The appeals process needs to establish whether the Trust's procedures have been adhered to and that the panel acted fairly and reasonably in coming to their decision. The appeal panel can hear new evidence and decide if this new evidence would have significantly altered the original decision. The appeal panel should not re-hear the entire case but should direct that the case is reheard if appropriate.

Composition of the panel – 3 people:

- **Chair**

An independent member from an approved pool (Refer to MHPS Annex A)

- **Panel 1**

The Trust Chair (or other non-executive director) who must be appropriately trained.

- **Panel 2**

A medically/dentally qualified member not employed by the Trust who must be appropriately trained.

Advisors to the Panel:

- a senior HR staff member
- a consultant from the same specialty or subspecialty as the appellant not employed by the Trust.
- Postgraduate Dean where appropriate.

Timescales:

- Written appeal submission to the HROD Director within 25 working days of the date of written confirmation of the original decision.
- Hearing to be convened within 25 working days of the date of lodgement of the appeal. This will be undertaken by the Case Manager in conjunction with HR.
- Decision of the appeal panel communicated to the appellant and the Trust's Case Manager within 5 working days of conclusion of the hearing. This decision is final and binding.

Powers of the Appeal Panel

- Vary or confirm the original panels decision
- Call own witnesses – must give 10 working days notice to both parties.
- Adjourn the hearing to seek new statements / evidence as appropriate.
- Refer to a new Clinical Performance panel for a full re-hearing of the case if appropriate

Documentation:

- All parties should have all documents from the previous performance hearing together with any new evidence.
- A full record of the appeal decision must be kept including a report detailing the performance issues, the Practitioner's defence or mitigation, the action taken and the reasons for it.

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerns and/or their colleagues. (MHPS Section II para 6)
- Exclusions may be up to but no more than 4 weeks at a time.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions.

Immediate Exclusion

A proposal to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director or Associate Medical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis. MHPS Section 1: para 18-27.

The Clinical Manager should notify NCAS of the Trust's consideration to immediately exclude a Practitioner and discuss alternatives to exclusion before notifying the Practitioner and implementing the decision, where possible.

The exclusion should be sanctioned by the Trust's Medical Director and notified to the Chief Executive. This decision should only be taken in exceptional circumstances and where there is no alternative ways of managing risks to patients and the public.

The Clinical Manager along with the HR Case Manager should notify the Practitioner of the decision to immediately exclude them from work and agree a date up to a maximum of 4 weeks at which the Practitioner should return to the workplace for a further meeting.

During and up to the 4 week time limit for immediate exclusion, the Clinical Manager and HR Case Manager must:

- Meet with the Practitioner to allow them to state their case and propose alternatives to exclusion.
- Must advise the Practitioner of their rights of representation.
- Document a copy of all discussions and provide a copy to the Practitioner.
- Complete an initial investigation to determine a clear course of action including the need for formal exclusion.

At any stage of the process where the Medical Director believes a Practitioner is to be the subject of exclusion the GMC / GDC must be informed. Consideration must also be given to the issue of an alert letter - Refer to (HSS (TC8) (6)/98).

Appendix 5

Restriction of Practice / Exclusion from Work (Section II MHPS)

Formal Exclusion

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

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

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

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

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

- There is a need to protect the safety of patients/staff pending the outcome of a full investigation
- The presence of the Practitioner in the workplace is likely to hinder the investigation.
- **NCAS must be consulted where formal exclusion is being considered.**

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

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The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

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

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

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

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager
This is the person to whom concerns are reported. This will normally be the supervising Consultant, Clinical Director or Associate Medical Director (although usually the Supervising consultant/Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial screening assessment along with a HR Case Manager.

Formal Process

Chief Executive
The Chief Executive in conjunction with the Medical Director appoints a Case Manager and Case Investigator. The Chief Executive will inform the Chairman of the formal investigation and request that a Non-Executive Director is appointed as "designated Board Member".

Case Manager
This role will usually be delegated by the Medical Director to the relevant Associate Medical Director. S/he coordinates the investigation, ensures adequate support to those involved and that the investigation runs to the appropriate time frame. The Case Manager keeps all parties informed of process and s/he also determines the action to be taken once the formal investigation has been presented in a report.

Case Investigator
This role will usually be undertaken by the relevant Clinical Director, in some instances it may be necessary to appoint a case investigator from outside the Trust. The Clinical Director examines the relevant evidence in line with agreed terms of reference, and presents the facts to the Case Manager in a report format. The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work nor should he/she make recommendations.

Note: Should the concerns involve a Clinical Director, the Case Manager should normally be the Medical Director, who can no longer chair or sit on any formal panels. The Case Investigator will be the Associate Medical Director in this instance. Should the concerns involve an Associate Medical Director, the Case Manager should normally be the Medical Director who can no longer chair or sit on any formal panels. The Case Investigator may be another Associate Medical Director or in some cases the Trust may have to appoint a case investigator from outside the Trust.
Any conflict of interest should be declared by all parties before proceeding with this process.

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must oversee the case to ensure momentum is maintained and consider any representation from the practitioner about his or her exclusion or any representations about the investigations.

Maintaining High Professional Standards Working Group

Action Points from Meeting 11th June 2012.

In attendance:

Dr Paddy Woods (Chair)
Dr Anne Kilgallen
Margot Roberts
Jane Lindsay

1. The RST Guidance document *Supporting Doctors to Provide Safer Healthcare* had been circulated to members prior to the meeting. All present agreed that this had some useful elements that could be included in the revision to the Guidance section of the draft revised MHPS, most notably the matrix for categorisation of concerns and the responsibilities of the RO in relation to managing concerns.

   Action: Jane to contact Dr Martin Shelly re use of elements of this document in revision of MHPS and further revise Guidance.

2. The CiC team have developed a draft *Managing Concerns Toolkit* that aims to bring all relevant Guidance together to facilitate HSC organisations to consider the range of options and required actions when addressing concerns. A list of Contents is included in Appendix 1 of this meeting note. Those present felt this would be very helpful and supported the approach taken. Suggested developments to the Toolkit were:
   - Providing a synopsis of the relevant document at the beginning of each section
   - Ensuring consistency of language and clarifying areas of overlap in each document to ensure it is consistent with the MHPS Framework and other relevant policies
   - Consideration of name for toolkit (*Aiming for Excellence* is a working title only)
   - Add DHSSPS Early Alert and the HSCB SAI Guidance to toolkit.

Action: ***Jane to develop document synopses & add additional Guidance***
Margo to clarify origin of classification of concerns in NIMDTA's framework for trainees and consider amending these to ensure consistency with MHPS.
All to consider potential name for Toolkit.

Appendix: Contents of Managing Concerns Toolkit

Aiming for Excellence: A Toolkit to Support HSC Organisations to Manage Concerns about Doctors and Dentists.

Contents:

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 2012 V 3.0

TABLE OF CONTENTS:

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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. 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 robust 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.

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3. This revision of Maintaining High Professional Standards is in 34 ~~4~~ Parts and is presented as part of a *Managing Concerns Toolkit* that brings together additional pertinent guidance and policy documents that organisations should ~~may~~ require ~~to reference or~~ follow ~~implement~~ when a concern is raised.

4. Now entitled *Maintaining High Professional Standards in the 21st Century*, the framework comprises 34 ~~4~~ parts:

Part 1: Guidance on Managing Concerns
~~**Part 2: Procedures for Exclusion from Work**~~
Part 23~~3~~: Procedures for Conduct Hearings and Disciplinary Processes
Part 34~~4~~: Procedures for Clinical Performance Processes
Appendix: Procedures for Exclusion from Work

5. 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.

~~6. HSC organisations must notify the Department of the action they have taken to comply with this revised framework by INSERT DATE~~

Background

~~7.~~6. 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.

~~8.~~7. 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 shortcomings ~~failures~~ in the delivery of care to prevent a re~~o~~ccurrence. Underperformance of healthcare professionals is one of many factors that can impact on the delivery of quality care.

~~9.~~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 practice. This approach recognises the importance of seeking to address ~~clinical~~ performance

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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 this is warranted.~~a situation may warrant this approach.~~

Purpose And Coverage Of The Revised Framework

~~10.~~ This framework ~~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.~~

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~~11.~~9. **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 on a regular basis ~~periodically~~ throughout the investigatory process.**

~~12.~~10. All HSC organisations ~~must~~ have established procedures for handling concerns about an individual's performance. These procedures must reflect those outlined in this framework. ~~and allow for agreed resolution of problems where deemed appropriate.~~

~~13.~~11. This guidance is applicable to all doctors and dentists employed by one of the six 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 Northern Ireland Medical and Dental Training Agency and the NI Blood Transfusion Service.

~~14.~~ Concerns in relation to the performance of doctors and dentists in training, the standards for which are outlined in the Gold[3] and Foundation[4] guidance ~~should~~, should be managed by employers in line with those for other medical and dental staff. It is, however, essential that the Postgraduate Dean, as Responsible Officer for doctors in training, is involved in these cases **from the outset**. The onus still rests with the employer for the conduct of the investigation and any necessary action. The *Managing Concerns Toolkit* contains information from the Deanery on addressing concerns in relation to trainees.

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~~15.~~12. Similarly, if t**he Northern Ire**land 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 who will proceed to pursue the concern.

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~~16.~~13. Guidance on managing concerns in General Practice has been developed by the DHSSPS; *The Prevention, Detection and Management of Underperformance in General Practice (April 2002)*. If a concern arises in respect of a doctor practising in an HSC Trust who is on the Primary Medical Performers List, the Responsible Officer of the Health and Social Care Board (HSCB) should be informed.

~~17.~~14. Where a case involves allegations of abuse against a child or a vulnerable adult, guidance issued to the HSC in 2006, *Safeguarding Vulnerable Adults* and the revised framework C*hoosing to Protect Children and Vulnerable Adults 2009* should be referred to and advice sought from the organisations' Adult and Child Protection officer .[5]

[3] The Gold Guide
[4] Foundation Guide
[5] http://www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf
AND http://www.dhsspsni.gov.uk/choosingtoprotectmarch2009.pdf

Field Code Changed

STRATEGIC CONTEXT OF THIS FRAMEWORK

~~18.~~15. Since 2005 there has been significant restructuring in the HSC, as well ~~as~~ ~~along~~ a number of recommendations for enhanced regulation of healthcare professionals.~~with proposals for new regulatory arrangements for doctors and dentists~~. Th~~ese,is,~~ 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

~~19.~~16. In November 2005, the DHSSPS ~~has~~ implemented a major programme of reform and modernisation in health and social care. The recommendations from the R~~r~~eview of P~~p~~ublic A~~a~~dministration (RPA) in 2002-05 were designed to establish modern, accountable and effective arrangements for public service delivery in Northern Ireland.

~~20.~~17. As their sponsor, the DHSSPS holds all HSC Bodies directly to account for fulfilling their ~~their good governance~~organisational governance responsibilities, of which this guidance and its processes framework are an element. . This accountability runs through the Minister to the Assembly and its committees.~~s.~~

~~21.~~18. Those responsible within HSC organisations for the implementation of the processes in this framework should be aware of these regional accountability arrangements[6] 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.

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PROFESSIONAL REGULATION OF DOCTORS AND DENTISTS

~~22.~~19. The implementation of the processes described in this document should also include consideration of the need to refer the practitioner to their professional

[6] http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

regulatory body, for dentists, the General Dental Council (GDC) and for doctors, the General Medical Council (GMC). Referrals made under fitness to practise 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[7] and the GMC have published referral thresholds for doctors, which can also be accessed via their website[8].

~~23.~~20. In addition, the GMC has~~ve~~ 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

~~24.~~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 practi~~se~~ing to the standards required by their regulator. Revalidation is a~~n~~ continuous ~~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

~~25.~~22. The GMC have ~~will~~ implemented ~~a system of~~ revalidation of ~~for~~ its registrants. ~~in late 2012.~~ All registrants with ~~ho~~ 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

Commented [JL6]: This paragraph will require updating - dependant on publication date revalidation will likely have commenced.

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

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

recommendation to the GMC that those doctors with whom they have a prescribed relationship should be revalidated.

~~26.~~ Legislation, (and supporting Guidance)[9] 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[10] identify those ~~HSC~~ organisations that are designated bodies, each of whom has appointed a Responsible Officer. ~~The Northern Ireland Medical and Dental Training Agency is also a designated organisation, making the Postgraduate Dean the Responsible Officer for doctors in training.~~

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~~27.~~23. 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.

~~28.~~24. This framework and associated Guidance contained in the Managing Concerns Toolkit will support the RO in exercising the functions prescribed in regulations outlined above.

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

Revalidation of ~~For~~ Dentis~~t~~al Practicioners ~~s~~

~~29.~~25. The General Dental Council (GDC) has 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 Professional Standards Framework.

REVALIDATION AND MANA~~N~~GING CONCERNS

~~30.~~26. 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.

~~31.~~27. A key principle in managing concerns, and in 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.

~~32.~~28. 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 through a robust appraisal system that examines a range of supporting information could allow for earlier intervention and remediation (where appropriate). This will allow practitioners to

~~opportunity to~~ address the area/s identified and provide an opportunity for these to be improved on wherever possible.

IDENTIFYING CONCERNS

What Constitutes a Concern?

~~33.~~29. The majority of practitioners provide a high standard of care to patients. The principles and values which underpin professionalism, and the behaviour required of a doctor or dentist, are described in the GMC's *Good Medical Practice* framework and the GDC's *Professional Standards* framework. As medical and dental practice and technologies evolve, practitioners need to enhance their skills and keep up to date, in order to remain fit to practise. They must also comply with their contractual obligations and the standards expected of them by their employers/s.

~~33. In the course of their professional career every practitioner will experience variation in the level of their practice, and clinical competence. Every practitioner will make mistakes and, on occasion, patients will come to harm as a result. All practitioners must therefore be vigilant in recognising, and taking responsibility for mistakes and for reductions in the quality of their practise. Learning from these will improve patient safety in the future.~~

~~34.~~30. A concern about practice can be said to have arisen where a single ~~n incident~~ incident occurs that causes or has the potential to cause, harm to a patient, staff or the organisation; or where the ~~practitioner develops~~practitioner develops a pattern of repeating mistakes, or appears to persistently behave in a manner inconsistent with standards required and expected both by their regulator and their ~~employer.~~employer. Concerns can arise in respect of a practitioner's behaviour, conduct or probity and t ~~T~~here will be varying ~~different~~ levels of severity in the concerns identified, as described in Table 1 of this Guidance. Careful analysis of the severity of the concern will guide an appropriate response.

How Concerns May Come to Light

~~35.~~31. The management of staff performance is an organisational ~~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 and addressed 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 should lessen ~~decrease~~ the ~~likelihood~~ likelihood ~~of the need~~ for an extensive investigation and/or implementation of disciplinary procedures.

~~36.~~32. 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.

~~36.~~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 for the most part ~~frequently~~ show that these can be attributed to systems or organisational shortcomings. ~~failures~~,

~~or demonstrate that the adverse event was an untoward outcome which could not have been predicted and is not the result of any individual or systems failure.~~

~~37.~~33. When a concern has been raised 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.

Raising a Concern about a Colleague

~~38.~~34. There is 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*[11] (2007~~),~~), which details the action programme in response to the Shipman inquiries and lessons learnt from the Ayling and Kerr/Haslam cases.

~~39.~~35. Each professional regulatory body defines standards of practice and behaviours they expect from their registrants, all of which include the requirement to take action if they perceive a risk to patient safety. Therefore, if a regulated healthcare professional does not report or take appropriate action to report or address a risk to patient safety, they will be in breach of their regulatory standards of practice. ~~Thus,~~ As such, there is an additional burden on health care staff subject to statutory regulation to report concerns.

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

~~40.~~36. All HSC organisations are required to ensure that they have a *Whistle Blowing*[12] policy and should ensure that an employee who wishes to raise a concern about a colleague is supported to do so.

~~41.~~37. Concerns raised about a colleague must, however, be based on concern for patient and / or staff welfare or the continuity of safe service provision within the ~~.~~organisation. 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.

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SUMMARY OF KEY ACTIONS NEEDED WHEN A CONCERN ARISES

~~42.~~38. When a concern is raised, and throughout the resulting processes, equal consideration should be given to both the investigation of the concern and action/s needed to ensure patient and public safety and maintain public ~~.~~ confidence. As such, the key actions needed at the outset can be summarised as follows:

- undertake a preliminary investigation to clarify the problem or concern
- ~~-~~review findings of preliminary investigation and identify next steps
- ~~-~~
- consider if immediate ~~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 if action is required to protect any potential evidence
- consider who should be informed of the concern
- consider necessity of completing an ~~Serious~~ Adverse Incident proforma.

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[12] http://www.dhsspsni.gov.uk/hss f 07 - 2009 whistleblowing.pdf

~~44.~~39. Decision making in respect of what action should be taken when a concern is identified can be informed by the use of a categorisation framework. This tool may support organisations to ensure that a consistent and defined methodology is applied as part of its M*anaging Concerns* policy.

~~45.~~40. An example framework is given below; it should be noted that escalation between the levels of categorisation should be clearly defined and that the level of concern may change at different points in the process as further information becomes available.

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Table 1: Categorisation Framework

Low Level Indicators	Moderate Level Indicators	High Level Indicators
Could the problem have been predicted?		
Unintended or unexpected incident		
What degree of interruption to service occurred?		
Incident may have interrupted the routine delivery of accepted practice (as defined by professional regulator) to one or more persons working in or receiving care		Significant incident which interrupts the routine delivery of accepted practice (as defined by professional regulator) to one or more persons working in or receiving care
How likely is the problem to reoccur?		
Possibility of reoccurrence but any impact will remain minimal or low. Recurrence is not likely or certain	Likelihood of recurrence may range from low to certain	Likelihood of recurrence may range from low to certain
How significant would a recurrence be?		
	Low level likelihood of recurrence will have a moderate impact (where harm has resulted as a direct consequence and will have affected the natural course of planned treatment or natural course of illness as is likely or certain to have resulted in moderate but not permanent harm) Certain level likelihood of recurrence will have a minimal or low impact.	Low level likelihood of recurrence will have a high impact (where severe/permanent harm may result as a direct consequence and will affect the natural course of planned treatment or natural course off illness such as a permanent lessening of function, including non-repairable surgery or brain damage)
How much harm occurred?		
No harm to patients and the doctor is not vulnerable or at any personal risk No requirement for treatment beyond that already planned	Potential for harm to staff or the doctor is at personal risk A member of staff has raised concerns about an individual which requires discussion and an action plan.	Patients, staff or the doctor have been harmed

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What reputational risks exist?		
Organisational or professional reputation is not at stake but the concern needs to be addressed by discussion with the practitioner	Organisational or professional reputation may also be at stake	Organisational or professional reputation is at stake
Does the concern impact on more than one area of practice?		
Concern will be confined to a single area of Good Medical Practice/ Professional Standards for Dentists May include one of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	Concern affects more than one area of Good Medical Practice/ Professional Standards for Dentists May include one or more of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	May include a serious adverse incident or complaint requiring a formal investigation This includes criminal acts and referrals to the professional regulator
Which factors reduce the level of concern?		
	De-escalation from moderate to low: Reduction to low or minimal impact Reduction in the likelihood of recurrence Evidence of completion of effective remediation	De-escalation from high to moderate: Reduction in impact to moderate Reduction in the likelihood of recurrence Evidence of insight and change in practice

Which factors increase levels of concern?		
Escalation from low to moderate: Increase in impact to moderate Likelihood of recurrence is certain No evidence of insight or change in practice	Escalation from moderate to high: Increase in impact to severe Increase in likelihood of recurrence No evidence of remorse, insight or change in practice	
How much intervention is likely to be required?		
Insight, remorse and change in practice will be evident Remediation is likely to achieved with peer support The practitioner has no other involvement in incidents or has outstanding or unaddressed complaints The remediation plan should take no longer than four weeks to address	Insight, remorse and change in practice may be evident Remediation is likely to achieved with specialist support The remediation plan should take no longer than three months to address	Remediation will only be achieved through specialist support The remediation plan will take upwards of three months and may include a planned period of supervised practice

PROTECTING PATIENTS AND THE PUBLIC

~~46.~~41. A risk assessment should be undertaken by a senior manager (with advice from a clinical colleague~~likely to be the RO/MD~~) 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.

~~47.~~42. The risk assessment should include consideration of the ~~the~~ need to share information with another organisation. As discussed in paragraph14, 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. If the concern relates to a General Practitioner, the RO of the Regional HSCB should be informed.

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~~48.~~43. The organisation will also wish to consider at this stage, and throughout any subsequent investigation, the need to initiate any of the following actions, guidance on which is contained in the *Managing Concerns Toolkit*:

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- Patient Service Reviews/ Look Back Exercise
- Requesting the issue of a Chief Medical Officer Alert Letter
- The need to initiate the DHSSPS Early Alert Protocol
- The need to complete an ~~Serious~~ Adverse Incident Report

- The need to communicate a Patient Safety Incident with Patients, Families and their Carers

SECTION 3: INVESTIGATION

~~49.~~44. This section outlines the key principles and best practice in undertaking an investigation of a concern.

~~50.~~45. Good practice in carrying out investigations of concerns can be summarised in the following principles, [13]:

- The overriding objective should be to protect the safety of patients and the public and to sustain public confidence
- 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 resourced
- Organisations must work to agreed timescales and practicioners ,ust comply with reasonable requests from their employer/s
- 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 when necessary, including occupational health assessment, recording when they have done so and how it has contributed to decision making.

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

UNDERTAKING AN INVESTIGATION

~~51.~~46. 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**. It is expected that a significant percentage of concerns will be resolved following a preliminary investigation. Actions that may be taken during and on completion of each type of investigation are described later ~~further on~~ in this Guidance.

~~52.~~47. It should be noted that if the practitioner is the subject of an ongoing investigation by the Police, the Counter Fraud and Probity Services (CFPS)[14] or a regulatory/ licensing body, this does not necessarily prevent an investigation into unrelated matters taking place. It would however, be advisable to consult the relevant organisation before commencing any investigation, for example the GMC's Employment Liaison Advisor. If an investigation has been commenced and the organisation becomes aware of another investigation, liaison with the relevant body should take place.

~~53.~~48. 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.

~~54.~~49. The following principles from the Labour Relations Agency [15] provide 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

[14] http://www.hscbusiness.hscni.net/services/Counter%20Fraud%20and%20Probity%20Services.htm
[15] http://www.lra.org.uk/index/agency_publications-2/advice_and_guidance_on_employment_matters-3/advisory_guides2/advice_on_conducting_employment_investigations.htm

- ***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/s 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 following the raising of a concern ~~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

~~54.~~ 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 objective and comprehensive ~~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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~~55.~~50. 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.

~~56.~~51. If any case is to proceed, evidence has to be demonstrated. While the rules of evidence can become complicated, there are some simple questions that should always be asked:

- ***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 15 years ago ~~in 1997 t~~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)

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- ***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 of much value ~~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

~~57.~~52. The investigatory process should commence with a preliminary investigation to methodically establish the facts surrounding the concern that has been identified. The purpose of this investigation is to establish the facts by ~~is first stage should~~ taking e account of the available information ~~evidence to hand,~~ alongside any comments the practitioner wishes to make~~,~~. This process ~~and~~ should provide an indication of the substance of the concern and the most appropriate course of action.

~~58.~~53. The appropriate nominated Director in the organisation ~~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 according to the organisational processes.

~~59.~~54. **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 recording will provide assurance to the organisation, and the practitioner, that the appropriate process has been followed and how decisions were reached.

~~60.~~55. The preliminary investigation should be undertaken by a suitably trained individual drawing on advice from a senior clinician in the HSC organisation and should include:

- Review of relevant clinical or administrative records

- Review of any report or documentation relating to the concern. If witness statements may not have been drafted at this stage, the

Commented [PW9]: Need to consider how relates to investigation of an adverse incident

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

~~61.~~56. 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 throughout the investigation. Their comments must be taken into consideration before any decision is reached in relation to any subsequent action. The investigator responsible for conducting a preliminary investigation should document their findings and their ~~decision~~ recommendation reached.

~~62.~~57. 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
- Consideration should be given to seeking ~~E~~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 and make appropriate changes

- The doctor or dentists should have the right to appeal against any decisions made, except for decisions to refer cases to the regulator, the Police or the Counter Fraud and Probity Service.

OPTIONS FOLLOWING PRELIMINARY INVESTIGATION

~~63.~~58. 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 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.

~~64.~~59. 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
- Health issue identified – appropriate advice and support secured from Occupational Health Service
- Measures to ensure patient safety required – restriction on practice or Immediate Exclusion
- Proceed to Stage 2- *Extended Investigation*

NO ACTION REQUIRED

~~65.~~60. 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. The practitioner should be informed of this decision as soon as possible and the record of the investigation completed. This should 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 reference.

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REMEDIAL ACTION REQUIRED

~~66.~~61. If the outcome of the preliminary investigation is the identification of a performance concern (as per definition in paragraph 5 of this Framework- referring to all aspects of a practitioner's work including conduct, health and clinical performance), consideration should be given to whether an action plan to resolve the problem can be agreed with the practitioner.

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~~67.~~62. The NCAS can advise on the practicality of this approach. The Action Plan should include achievable objectives within a realistic and defined timescale and progress towards fulfilling the objective should be regularly reviewed.

HEALTH ISSUE IDENTIFIED

~~68.~~63. If it becomes apparent during the preliminary investigation that the practitioner has a health issue, support and advice should be sought from the Occupational Health Service (OHS). The practitioner should be informed prior to a referral being made to this service and their consent obtained.

~~69.~~64. If the practitioner refuses to give consent for such a referral, this may indicate a need to progress to an extended investigation to fully explore the potential impact of the health issue on patient and public safety, and the degree of insight the practitioner may have in respect of their health issue. Appropriate support should be made available to the practitioner during this process.

MEASURES TO ENSURE PATIENT SAFETY

RESTRICTIONS ON PRACTICE

~~70.~~65. 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.

~~71.~~66. 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.

~~72.~~67. **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

~~73.~~68. An immediate time limited exclusion from the workplace at any stage of investigation of a concern 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 or undermine effective delivery of the service.~~.~~

~~73.~~ 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 through an Extended Investigation~~. A situation analysis should be undertaken and a case conference convened involving the clinical manager, the Medical Director/Responsible Officer and appropriate representation from Human Resources.~~

Commented [JL11]: Clarify at what point this should happen-prior to exclusion? Does this refer to a preliminary investigation?

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~~74.~~69. 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.

~~75.~~70. 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.

~~76.~~71. 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.

~~77.~~72. All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

~~78.~~73. The 4 week exclusion period should allow sufficient time for initial or extended further investigation to determine a clear course of action, including the need for a further exclusion, remediation, disciplinary action and/or referral to the regulator. The procedures to be followed should an extended investigation indicate that a longer period of exclusion is required are outlined further on in this Guidance.

Commented [JL12]: See comment 5

~~79.~~74. 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. Consideration should also be given to the need to issue an Alert Letter and the need to inform any other organisation the doctor or dentist may practise in.

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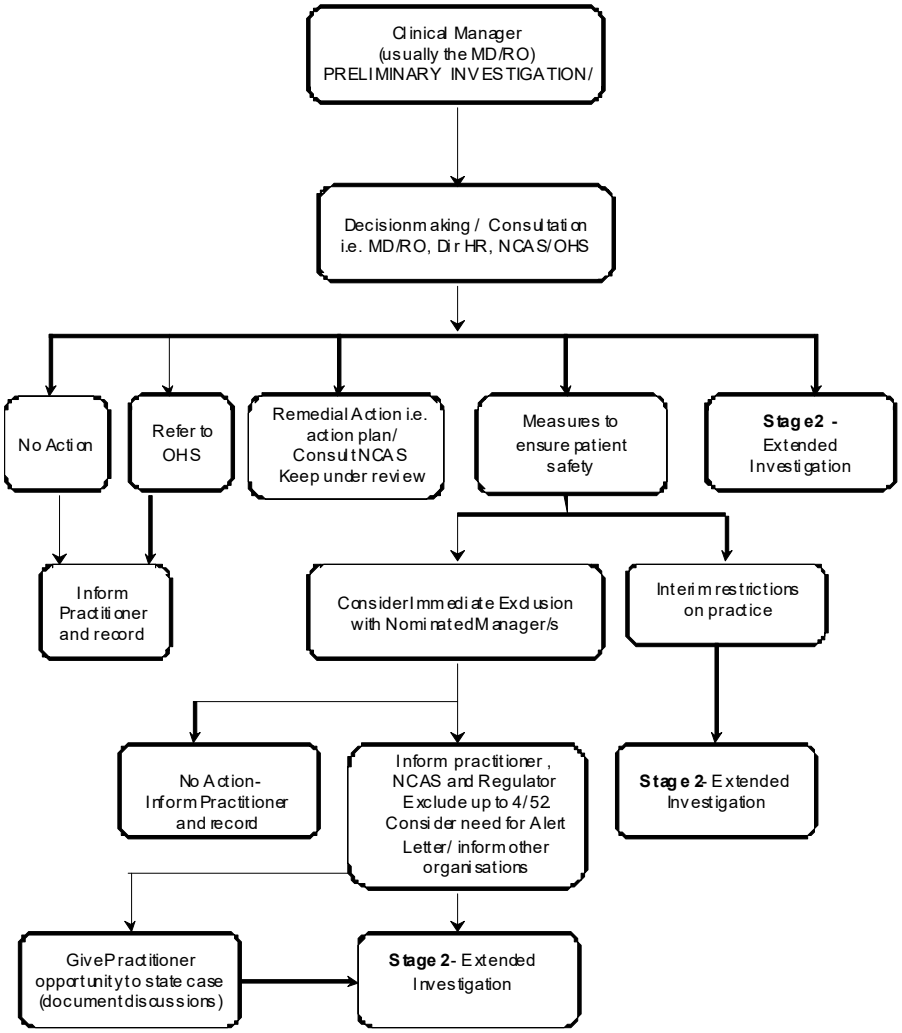
STAGE 1- PRELIMINARY INVESTIGATION AND ACTIONS ARISING



STAGE 2: EXTENDED INVESTIGATION

~~80.~~75. An extended investigation will be necessary under the following circumstances:

- The preliminary investigation has resulted in an Exclusion/ restrictions on practice and referral to the professional regulatory body
- The preliminary investigation was insufficient in establishing the facts surrounding the concern
- The preliminary investigation uncovered additional areas of concern and demonstrated potential risk/s of harm to the patients, staff or the practitioner
- The preliminary investigation uncovered evidence of actual harm to patients, staff or the practitioner
- The preliminary investigation uncovered evidence of a criminal act requiring referral to the PSNI/ Counter Fraud Unit
- It is clearly evident that conduct or clinical performance processes are an inevitable outcome of addressing the concern

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~~81.~~76. Organisations should also consider commencing an extended investigation in the following circumstances:

- The practitioner has not complied with an Action Plan established following a preliminary investigation
- The practitioner fails to avail of remediation opportunities made available by the Organisation to support them to improve their practice

Commented [JL13]: My criteria- input required from PW/Steering Group

~~82.~~77. Where it has been established decided that an extended investigation should be undertaken the Chief Executive (CE) must, after discussion between the Responsible Officer/Medical Director and Director of HR, appoint a Case Manager (CM), a Case Investigator (CI) and a Designated Board Member (DBM). The seniority of the CI will differ depending on the grade of practitioner involved

in the allegation. Several CI's in the organisation should be appropriately trained to enable them to carry out this role.

~~83.~~78. The table below summarises the roles of those involved in an extended investigation:

Title	Qualification	Role
Chief Executive (CE)	Accounting Officer for organisation	- Appoints CM,CI and DBM - Responsibility for organisational processes and policies
Case Manager (CM)	Normally MD/RO. If MD/RO is subject of the investigation a medically qualified manager of equivalent seniority should be appointed	- Leads the investigation - Undertakes risk assessments throughout the investigation - Decides on appropriate action based on outcome from extended investigation - Collaborates with HR/OHS colleagues as requires - Ascertains the need for escalation and / or additional measures to protect patients
Case Investigator (CI)	Medical or dental practitioner appropriately trained	- Undertakes the investigation to establish the facts as described in paragraphs 59-64 - Escalates information that may result in the need for additional measures to protect patients to the CM as and when it is discovered - Submits a report outlining findings from the investigation to the CM within agreed timescales
Designated Board Member (DBM)	Member of the organisation's Executive Board	- Oversees the case - Ensures momentum is maintained - Considers any representations from the practitioner or others in relation to the investigation.

~~84.~~79. At any stage of the extended investigation 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.

~~85.~~80. The investigatory approach described in paragraphs 50-56 of this document applies to both preliminary and extended investigations.

~~86.~~81. Employers must ensure that managers and CI's 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

~~87.~~82. The Board of the organisation, through the CE, has responsibility for ensuring that these processes are established and followed. It should be noted that Board members may be required to sit as members of a disciplinary or appeal panel, therefore, information provided to them should only be sufficient to assure that this process is being followed. The exception to this will be for the Designated Board Member whose role is to:

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

~~88.~~83. If the MD/RO is the subject of the investigation, the CE of the organisation should appoint a suitable medically qualified manager of at least equivalent seniority.

~~89.~~84. The CM must ~~be~~ inform the practitioner in writing that an investigation is to be undertaken, the name of the Case Investigator and the nature of the ~~specific~~ allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people 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 as described in paragraph 85.

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~~90.~~85. 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 an external body such as the NCAS/Medical Royal College be invited to assist. ~~elsewhere be invited to assist.~~

~~91.~~86. 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 risk to patient and public safety.

INVESTIGATION

~~92.~~87. 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 or dentally qualified where possible.

~~93.~~88. 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.

~~94.~~89. If the concern relates to an issue regarding clinical judgement, the CI should involve a senior member of the medical or dental staff[16] with relevant clinical experience in the investigation.

~~95.~~90. The CI must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality must be maintained.

~~96.~~91. It is the responsibility of the CI 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.

~~97.~~92. A written record must be maintained during the investigation that records the conclusions reached and the course of action agreed by the Case Manager ~~Medical Director~~ with advice from the Director of HR.

~~98.~~93. The CI must assist the DBM 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 suggests a risk to patient or public safety, the CI must inform the CM and DBM immediately to allow consideration of measures required mitigate this risk.

Commented [JL14]: My insertion

~~99.~~94. 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.

[16] 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.

TIMESCALES AND DECISION MAKING

~~100.~~95. The CI should, other than in exceptional circumstances, aim to complete the investigation within 4 weeks of appointment and submit their report to the CM within a further 5 working days. The CM must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the CI.

~~101.~~96. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the CM 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.

HANDLING OF ILLNESS ARISING DURING EXTENDED INVESTIGATION

~~102.~~97. If an excluded employee or an employee facing any process 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.

~~103.~~98. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS in accordance with the organisation's policy on managing attendance. ~~.~~ 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.

~~104.~~99. 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.

OPTIONS FOLLOWING AN EXTENDED INVESTIGATION

~~105.~~100. The CI's report should give the CM sufficient information to make a decision on whether:

- no further action is required
- measures to protect patients are 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.

~~106.~~101. **The above measures are not mutually exclusive; it may be necessary to implement measures to protect patients alongside action to**

support the practitioner or address issues of conduct and performance. Further detail on these options is provided below.

No Further Action Required

~~107.~~102. 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.

Measures to Protect Patients Are Required

~~108.~~103. The process for implementing an *Immediate Exclusion* is described in paragraphs 75-82 of this Guidance. Further detail on this and the *Formal Exclusion* process can be found in **Part 2.**

Case of Misconduct- Proceed to Conduct Panel

~~109.~~104. **Part 3** of this framework outlines the process to be implemented if there is a case of misconduct that must be put to a misconduct panel.

Health Concerns

~~110.~~105. When the findings of an extended investigation demonstrate there are concerns about the practitioner's health, these should be considered by the HSC body's Occupational Health Service (OHS) and the findings reported to the employer.

~~111.~~106. In addition, if at any stage in the context of managing 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.

~~112.~~107. 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.

~~113.~~108. 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~~/~~ or their appropriate nominee. ~~Responsible Officer.~~ 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)[17]. The practitioner may be accompanied to these meetings (as defined in paragraph 85). Confidentiality must be maintained by all parties at all times.

~~114.~~109. The findings of OHS may suggest that the practitioner's health presents a risk 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.

~~115.~~110. 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.

~~116.~~111. A practitioner who is subject to the conduct hearings/disciplinary procedures/ clinical performance procedures may put forward a case on ill health

[17] 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.

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

~~117.~~112. Wherever possible the organisation should attempt to continue to employ the individual provided this does not place patients or colleagues at risk in accordance with their policy on Redeployment of Staff. 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.

~~118.~~113. Examples of action to take:

- sickness absence for the practitioner (the practitioner should be contacted frequently to ensure they receive any support they may require);
- 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)

~~119.~~114. 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.

~~120.~~115. 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 colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

~~121.~~116. 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.

~~122.~~117. 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.

Clinical Performance Concerns- Referral to NCAS

~~123.~~118. 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 which 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.

~~124.~~119. Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered.

~~125.~~120. 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 work systems than a doctor's performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

~~126.~~121. 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.

~~127.~~122. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practise in the HSC or independent sector other than their main place of HSC employment until the NCAS assessment is complete

~~128.~~123. Failure on the part of either the clinician or the employer to cooperate 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.

Referral to Professional Regulator Required

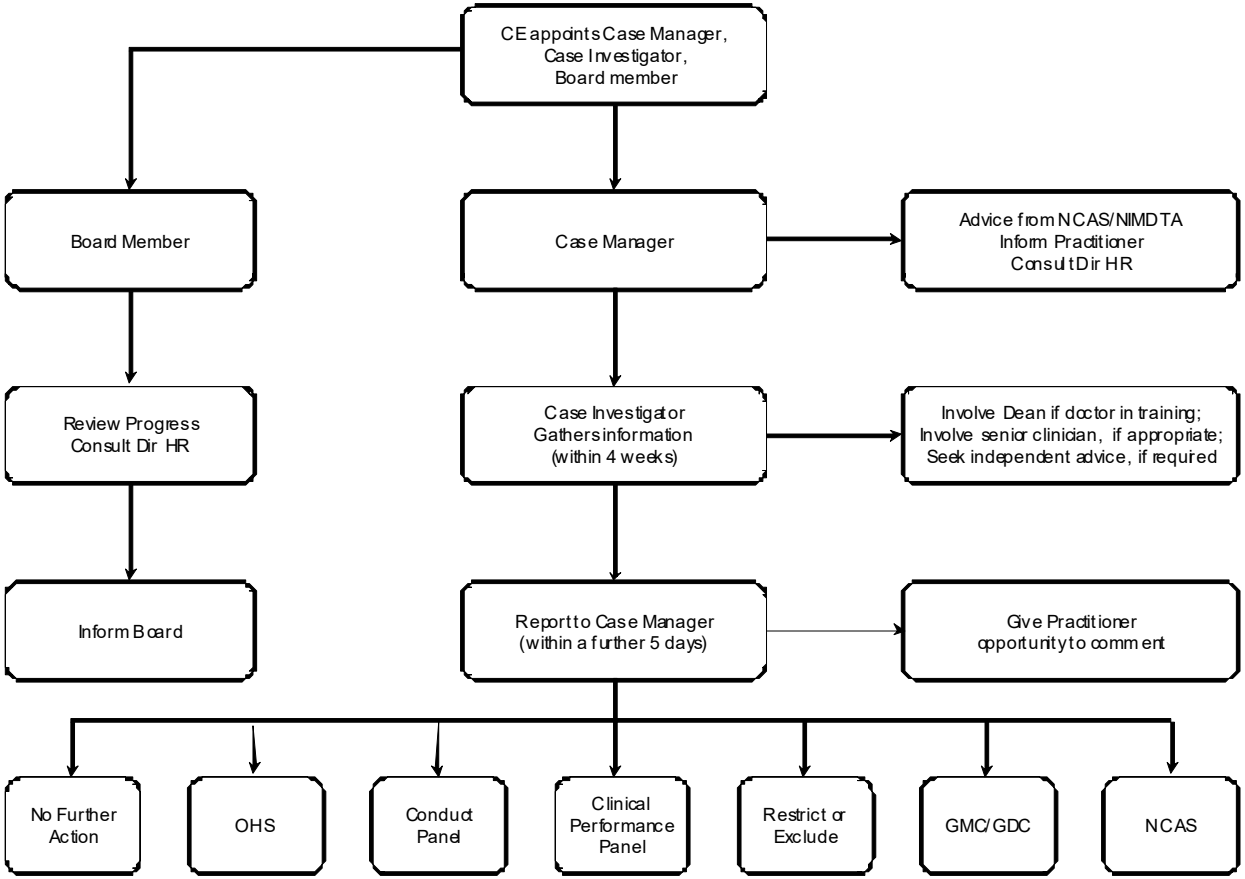
~~129.~~124. The GMC and GDC have developed guidance for fitness to practise referrals. Paragraphs 21-22 of this Guidance provides further detail on referrals to a professional regulatory body.

Irretractable Problems – Clinical Performance Panel

~~130.~~125. Part 4 of this Framework outlines the process to be implemented where there has been a clear failure by an individual to deliver care to an acceptable standard due to clinical performance issues.

~~131.~~126. The process for an Extended Investigation and the possible actions arising are summarised on the below diagram.

STAGE 2: EXTENDED INVESTIGATION AND ACTIONS ARISING



PROCESS FOR SMALLER ORGANISATIONS

135. 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.

136. 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 [JL15]: Does this refer to resignation? Can this extend to trainees who move to another organisation?

137. 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.

138. 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.

139. 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 and/or the Independent Safeguarding Authority

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

140. 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

141. 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.

142. Personal data released to the CI for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

Maintaining High Professional Standards in the 21st Century:
Part 2 Guidance on Managing Concerns

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Part 23 – Conduct Hearings and Disciplinary Processes

INTRODUCTION

1. This section applies when the outcome of an ~~investigation~~extended investigation ~~under Section I~~ demonstrates ~~shows that there is~~ a case of misconduct that 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.

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.

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. 18

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.

[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

CODES OF CONDUCT

6. Every HSC ~~PSS~~ 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 body19;
- 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.

[19] 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

11. Action when investigations identify possible criminal acts

12. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case 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 HSC Counter Fraud and Probity Service at the Business Services Organisation (BSO) must be contacted.

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

13. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to 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.

14. 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

15. 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.

16. 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.

Part ~~4~~ 3– Clinical Performance Panels

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 Part 1 of this Guidance. 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 Part 1 ~~Section I~~ **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).

Commented [JL16]: What happens in this situation?

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

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

Wherever possible such issues should be dealt with through the options described in Section 1 paragraphs 65-82 ~~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 paragraphs 113-125 in Part 1 of this framework.

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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.

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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[20].

7. As set out in Part 1of this Framework (paras 126-131), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been

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

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 Service ~~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.[21] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

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

- a senior member of staff from Human Resources;
- an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HPSS employer;
- 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 ~~PSS~~/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.

[21] 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

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

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

Conduct of the clinical performance hearing

15. The hearing should be conducted as follows:

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

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

The order of presentation shall be:

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

Decisions

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

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

ii. 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.

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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

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

Membership of the appeal panel:

- an independent member (trained in legal aspects of appeals) from an approved pool.[22] 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

[22] See Annex A.

is not employed by the Trust[23] 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~~PSS~~/NHS employer [24];
- 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 28. 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.

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:

[23] 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.
[24] 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.

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~~PSS~~ disciplinary procedures.

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Appendix - Measures to Protect Patients

Process for Exclusion from Work

1 ~~This part of the framework replaces the guidance in HSS (TC8) 3/95 (Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff - Suspensions).~~ Under the Directions on Disciplinary Procedures 2005, ~~HSC employers~~HSC 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.

~~1 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 practise hearing).~~

2 The Directions require that HSC bodies must ensure that:

- exclusion from work is used only as an interim measure whilst action to investigate and resolve a concern 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

3 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.

4 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.

5 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

6 **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.

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Key principles of exclusion from work

7 Key aspects include:

- an initial "immediate" exclusion of no more than four weeks if warranted as set out in Section 1 of this Guidance
- 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

8 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

9 A formal exclusion may only take place in the setting of an extended 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.

10 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.

11 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.

12 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.

13 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.

14 The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the nature ~~content~~ of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 19, and the need to remain available for work paragraph 20) and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

15 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. 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.

16 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.

17 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

18 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

19 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).

20 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

21 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[25] and the employer should ensure that other employers have been made aware of this decision.

22 Where the Case Manager has good grounds to believe that the practitioner is practising 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 Chief Medical Officer of the Department to consider the issue of an alert letter.

23 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.

[25] 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.

Existing suspensions & transitional arrangements

24 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

25 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

26 The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[26]. 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

[26] 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.

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.

27 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.

EXCLUSION REVIEWS

STAGE	ACTIVITY
First and second reviews (and reviews after the third review)	Case manager reviews the position before the end of each exclusion (of up to 4 weeks). 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. Case must be formally referred back to the NCAS explaining why continued exclusion is thought to be appropriate and what steps are being taken to complete the investigation at the earliest opportunity. The NCAS will review the case and advise the HSC 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.

28 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

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

30 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

31 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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From the Chief Executive and Registrar

General Medical Council

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350 Euston Road
London NW1 3JN

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Chair
Professor Sir Peter Rubin

Chief Executive
Niall Dickson

20th September 2012

Paddy Woods
Deputy Chief Medical Officer for Safety & Quality
Department of Health, Social Services and Public Safety
Castle Buildings, Stormont Estate
Belfast,
BT4 3SQ

PW/0025/2012

Dear Paddy,

This time last year we consulted on major changes to the way we deal with cases at the end of an investigation. The response we received to the proposals was positive and we are now developing plans to take them forward.

Meetings with doctors

A key reform was for the GMC to meet with doctors at the end of an investigation to ensure we fully understand the nature of any risk to patients and to provide the doctor with an opportunity to accept our proposed sanction without the need for a hearing.

We know that public hearings can be stressful for everyone involved and where there is no significant dispute about the facts and the doctor is willing to accept the sanction we propose, we do not believe a hearing is necessary. Our objective is to speed up the fitness to practise process and where we can to make it a less traumatic experience.

Full implementation, in particular enabling doctors to accept suspension or erasure, would need changes to legislation. In the meantime, we are planning to pilot meetings with doctors within our existing procedures.

During the pilot we would only agree undertakings with doctors where appropriate. Undertakings will continue to be published on our website except where they relate to a doctor's health. The pilot which will start on 24 September at our London offices will be independently evaluated.

Meetings with complainants

We are also piloting meetings with complainants at the start and end of the process. At the outset of a case we will explain our procedures and make sure we understand their concerns, and at the end of the case we will meet to explain our decision. The pilot is

being run in two regional areas close to our London and Manchester offices. This pilot will also start on 24 September and again it will be independently evaluated.

I enclose two leaflets explaining how the pilots will work. We would be more than happy to discuss the pilots with you as well as our long-term plans for fitness to practise if you would find this helpful. And if you have any questions about any of this, please do not hesitate to contact me or Paul Philip, our Deputy Chief Executive on Personal Information redacted by the USI

Personal information redacted by USI

Niall Dickson

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
A TOOLKIT TO SUPPORT HSC ORGANISATIONS
TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

SECTION 1

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MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
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TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

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TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

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MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
A TOOLKIT TO SUPPORT HSC ORGANISATIONS
TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

SECTION 4

MANAGING CONCERNS IN PRIMARY CARE:

This document details the outputs from a working group formed in April 2002. The introduction references previous work and publications, whilst outlining the potential causes of under-performance. The system of management then current is described and methods of prevention together with processes to aid recognition and assessment are examined. The main recommendations were that the then HSS Boards should develop a consistent, transparent approach to identify issues and provide supportive intervention; having the power to suspend without prejudice where serious concerns were raised. The group recommended that local mechanisms should be established to ensure all staff working in general practice were aware of the structure and processes of procedures.

The formation of Local Advisory & Investigative Panels as tools of assessment was also recommended.

The remit and membership of the Working Group is included at Appendix A, a summary of the current disciplinary and regulatory arrangements at Appendix B. Appendices C-G provide diagrammatic illustration of processes to deal with performance problems, details of legal considerations, of the Manchester Performance Panel Criteria and references to other publications.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
A TOOLKIT TO SUPPORT HSC ORGANISATIONS
TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

SECTION 5

MANAGING CONCERNS ABOUT TRAINEES

This policy document from NIMDTA aims to promote early identification and provide structures for addressing concerns in relation to Trainees.
Responsibilities are clarified, the various means by which concerns about trainees may come to light are listed and the types of problems most commonly encountered discussed. Appropriate actions to be taken and communications between bodies with which the trainee has a relationship are outlined. The importance and protocol for maintaining records and transferring information is documented; outputs from appraisal and assessment are noted as being essential elements of the range of information which should be maintained about trainees.
Section 8 provides a more detailed examination of the roles and responsibilities of each medical/education professional with whom the Trainee will come into contact. This section is supported by Appendix 1 which provides flowchart illustrations showing the contacts trainees have with supervisors/trainers and the routes and processes to be followed to bring concerns to resolution once they are identified.
Appendix 2 provides a checklist for educational supervisors/trainers to guide them in identifying and managing concerns.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
A TOOLKIT TO SUPPORT HSC ORGANISATIONS
TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

SECTION 6

INFORMATION SHARING TO PROVIDE ASSURANCE/DUTY OF CO-OPERATION

This guidance was developed in May 2011 by the Confidence in Care Programme; established to deliver the recommendations of the White Paper *Trust, Assurance and Safety* following a series of high profile mal practice and information sharing systems failures.

Section 1 provides some background to the rational for the development of the guidance. Work completed by local and national groups set up to examine options for information sharing is referenced. The purpose of the guidance is to provide an aid to healthcare organisations in determining why, when and with whom information relating to individual conduct or performance issues should be shared and explores to what extent patients or the public should be made aware of such information, particularly where an investigation is underway.

Section 2 outlines the broad principles on what information should be available locally and who should have access to it
Section 3 establishes the circumstances in which performance and conduct information could or should be shared between HSC organisations.

Section 4 sets out the current and short-term arrangements around storage and access to information.

This Guidance is not intended to act as a blueprint to inform the investigation of concerns or to replace existing local and regional guidance and policies which address the investigation of concerns. Rather, the guidance seeks to support local decision making based on the knowledge, skill and expertise of those using it against a background of effective systems of clinical and social care governance.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
A TOOLKIT TO SUPPORT HSC ORGANISATIONS
TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

SECTION 7

GUIDANCE ON ISSUING ALERT LETTERS

This section contains 2 documents: -

Circular HSS(TC8) 6/98
This circular advised HSS Boards and Trusts of a review of arrangements for the issue of alert letters. The system, already in place for some time, places a requirement upon Boards and Trusts to notify the Department of medical/dental staff who were dismissed or suspended, or where reasonable grounds existed to indicate they may be a potential danger to the safety of patients or others. An alert letter is then issued by CMO to HSS Boards and Trusts in order that they may be aware and seek further information from the originating organisation should the individual seek employment with them.

This issue of Circular HSS(TC8) 6/98 restates the background to the alert letter system and also serves as a reminder to HSS organisations of the importance of pre-employment checks on registration and from previous employers.

Paper 'Alert Letters for statutory regulated health care workers in N Ireland'

This paper outlines the systems and processes currently in place for the issue of alert letters by CMO.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
A TOOLKIT TO SUPPORT HSC ORGANISATIONS
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SECTION 8

REMEDIATION

The NCAS '*Back on Track Framework for Further Training*,' provides information on the service available to organisations from NCAS when dealing with practitioners who require further training when concerns have arisen about practice or to support a return to work programme.

The content examines who might need training and why, options for funding and defines responsibilities. A step by step guide to the stages of the process is included.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
A TOOLKIT TO SUPPORT HSC ORGANISATIONS
TO MANAGE CONCERNS ABOUT DOCTORS AND DENTISTS

SECTION 9

CONDUCTING PATIENT SERVICE REVIEWS AND LOOK BACK EXERCISES

This paper drawing from the past experiences of HSC Trusts, provides a guide to others who may need to take part in similar exercises in the future.

The guide looks at:
how the decision to carry out a patient service review or look back exercise is reached, suggests who should be involved at planning stage and the approach to be taken, discusses means and timing of communication with patients the role of the service review team and measures which must be in place to manage further clinical assessments if needed support to be provided to patients, including a helpline and how it should be managed together with a patient database.

The document includes appendices illustrating processes by flowcharts, examples of review pro-formas and samples of draft letters

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
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SECTION 10

BEING OPEN: COMMUNCATING PATIENT SAFETY INCIDENTS

The NHS, National Patient Safety document 'Being Open' addresses how healthcare staff can communicate with patients openly and honestly in situations where patient safety incidents occur.

The framework outlines a policy and principles for 'being open' with patients, families and carers and suggests a process and timeline of events and communications relating to a specific incident.

The importance of the consideration of the needs of the patient, or their family or carers is discussed, and also how the 'being open' process can be promoted by providing support to staff and through securing robust leadership from organisational Boards.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
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SECTION 11

GMC GUIDANCE – RAISING AND ACTING ON CONCERNS ABOUT PATIENT SAFETY

The GMC guidance document is based on 'the expectation that doctors will take appropriate action to raise and act on concerns about patient care, dignity and safety.'

In two parts the guidance advises on how to approach raising a concern in the workplace or with a regulator; how a concern once identified should be acted upon and investigated and suggests sources of support.

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE 21ST CENTURY:
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SECTION 12

HEALTH and SOCIAL CARE BOARD

PROCEDURE FOR REPORTING AND FOLLOW UP OF SERIOUS ADVERSE INCIDENTS

ALSO: RELATED DHSSPS POLICY CIRCULAR HSC (SQSD) 10/2010 –
EARLY ALERT SYSTEM

This HSCB document was published and circulated in line with the Departmental Circular HSC (SQSD) 08/2010 which advised of the transfer of responsibility for managing SAI's from DHSSPS to the HSCB and PHA wef 1st May 2010. The accompanying Circular HSC (SQSD) 10/2010 provides specific guidance on Early Alert System arrangements to notify the Department of events or potential SAI's which may require urgent attention or action.

The HSCB document outlines who the procedure applies to, incidents now excluded from the process and references other reporting arrangements which will continue to operate in parallel.

Serious Adverse Incident is defined by criteria and the process for reporting and following up set out

A number of appendices provide flow chart illustration of the process and example reporting forms/guidance notes.

Roberts, Naomi

From: Lindsay, Jane <[redacted]>
Sent: 19 November 2012 11:46
To: Woods, Paddy
Cc: Hutchison, Ruth
Subject: MHPS
Attachments: Maintaining High Professional Standards in the 21st Century V 2.0.tr5; Maintaining High Professional Standards in the 21st Century V 2.0.DOC

Follow Up Flag: Follow up
Flag Status: Flagged

Paddy

Are you content for this to be shared with Steering Group members ahead of Friday's meeting? I doubt you have had an opportunity to read as yet given the past week's schedule.

J

From: Hutchison, Ruth
Sent: 09 November 2012 17:14
To: Woods, Paddy
Cc: Lindsay, Jane
Subject: FW: MHPS

Paddy

MHPS as promised!

Regards
Ruth

Ruth Hutchison
Programme Support Officer
Confidence in Care Programme
Room C3.20, Castle Buildings
Belfast BT4 3SQ

Tel: [redacted]
Email: [redacted]

From: Lindsay, Jane
Sent: 08 November 2012 15:46
To: Hutchison, Ruth
Subject: MHPS

Ruth

Can you please proof read and fix any formatting issues, in particular the first flow chart and the headers in Parts 2-4 thanks.

J

Jane Lindsay
Programme 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

Roberts, Naomi

From: Reid, Simon
Sent: 27 November 2012 17:39
To: Lindsay, Jane
Cc: Woods, Paddy; Hutchison, Ruth
Subject: FW: Maintaining High Professional Standards Focus Group - Meeting at 11:30am on 23rd November in Dr Woods Office, Castle Buildings
Attachments: Maintaining High Professional Standards in the 21st Century V 2.0.DOC; Maintaining High Professional Standards in the 21st Century V 2.0.tr5

Hi Jane

Please find attached the comments I had promised to send on. As I said at the meeting these are really from a dental perspective and don't relate to the various processes described.

1. Para 1. I suppose that it depends who will be reading this guidance but I think it is useful to be completely clear that this doesn't apply to the vast majority of dentists working within HSC as independent contractors (and similarly I suppose wouldn't apply to GMPs). I feel it is important to stress (in the last line) that this only applies to concerns relating to dentists employed by the Trusts i.e. those working in the Community Dental Services or Hospital Dental Services. (If this guidance is strictly for internal use within Trusts then this may not be an important issue).
2. Para 13. Similar to point above. Do we need a line that it does not apply to doctors and dentists working as independent contractors to the HSCB?
3. Para 15. It might be helpful to describe the training as 'higher' or 'further' training for clarity and to distinguish from undergraduate training?
4. Para 29. Revalidation for dentists. I would suggest changing "external verifiers will be established and they will be required to review the supporting evidence" to "external verifiers have been proposed who would review the supporting evidence" as this is still a proposal. I would then add something like "the process will be subject to on-going development and potential modification with a further consultation" to reflect the current status.
5. Footnote reference 19 on page 64. The dental standards being referred to, 'Maintaining Standards' are a previous 1997 incarnation (http://gdc-arf.com/Newsandpublications/Publications/Publications/MaintainingStandards%5B1%5D.pdf). The current standards are actually 'Standards for Dental Professionals' 2005 (reprinted 2009) (http://www.gdc-uk.org/Newsandpublications/Publications/Publications/StandardsforDentalProfessionals[1].pdf). Co-incidentally new standards are under development and a consultation has just opened (http://www.gdc-uk.org/GDCcalendar/Consultations/pages/Review-of-Standards-Consultation.aspx)but I think we'll have published MHPS before they are introduced.

Hope this helps from a dental perspective but the document reads well and with Mervyn's comments on the processes and the discussions from last Friday I think that the key amendments will make it even better.

Kind regards
Simon

PS I tried copying in Mervyn, Anne and Margot but Outlook didn't seem to recognise their addresses from Ruth's original e-mail and I don't have their e-mail addresses.

From: Hutchison, Ruth
Sent: 19 November 2012 13:40
To: Barkley, Mervyn; Kilgallen Anne Western H.S.C. Trust; Reid, Simon; Roberts, Margot
Cc: Davey, Noreen; Beck, Lorraine; Dardis, Pauline; Garrett, Elizabeth; Woods, Paddy; Lindsay, Jane

Subject: Maintaining High Professional Standards Focus Group - Meeting at 11:30am on 23rd November in Dr Woods Office, Castle Buildings

Dear Colleagues

Please find attached the revised version of Maintaining High Professional Standards which will be the subject of discussion at Friday's meeting.

Thank you

Regards
Ruth

Ruth Hutchison
Programme Support Officer
Confidence in Care Programme
Room C3.20, Castle Buildings
Belfast BT4 3SQ

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

From: Hutchison, Ruth
Sent: 09 October 2012 15:33
To: 'Mervyn Barkley'; 'anne.kilgallen Personal Information redacted by the USI '; Reid, Simon; Roberts, Margot
Cc: 'Davey, Noreen'; 'Beck, Lorraine'; Dardis, Pauline; 'Garrett, Elizabeth'; Woods, Paddy; Lindsay, Jane
Subject: RE: Maintaining High Professional Standards Focus Group - Meeting Rescheduled for 11:30am on 23rd November in Dr Woods Office, Castle Buildings

Dear All

Please note the above meeting is now confirmed.

Thank you

Regards
Ruth

Ruth Hutchison
Programme Support Officer
Confidence in Care Programme
Room C3.20, Castle Buildings
Belfast BT4 3SQ

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

From: Hutchison, Ruth
Sent: 09 October 2012 09:59
To: 'Mervyn Barkley'; 'anne.kilgallen Personal Information redacted by the USI '; Reid, Simon; Roberts, Margot
Cc: 'Davey, Noreen'; 'Beck, Lorraine'; Dardis, Pauline; 'Garrett, Elizabeth'
Subject: RE: Maintaining High Professional Standards Focus Group - POSTPONEMENT of Meeting 8th October

Dear all

Would 11:30am on Friday 23rd November suit everyone for this meeting at Castle Buildings?

Dr Kilgallen's office have advised already that this date/time would be suitable to her.

Thank you

Regards
Ruth

Ruth Hutchison
Programme Support Officer
Confidence in Care Programme
Room C3.20, Castle Buildings
Belfast BT4 3SQ

Tel: Personal Information redacted by the USI
Email: 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
December ~~November~~ 2012 V ~~4~~3.0

TABLE OF CONTENTS:

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Commented [JL2]: Removed as Annex

Maintaining High Professional Standards in the 21st Century:
Part 1 Guidance on Managing Concerns

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.~~.~~ xxxxxxxxxxx

~~2.~~1. 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 robust 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. Test to save xxxxxxxxx

Commented [JL3]: Insert ref to Stat Duty of Quality 2003

~~3.~~2. This revision of Maintaining High Professional Standards is in 3~~4~~ Parts and is presented as part of a *Managing Concerns Toolkit* that brings together additional pertinent guidance and policy documents that organisations should ~~may~~ require ~~to reference or~~ follow ~~implement~~ when a concern is raised. Test to save

~~4.~~3. Now entitled *Maintaining High Professional Standards in the 21st Century*, the framework comprises 3~~4~~ parts:

Part 1: Guidance on Managing Concerns
~~**Part 2: Procedures for Exclusion from Work**~~
Part 2~~3~~: Procedures for Conduct Hearings and Disciplinary Processes
Part 3~~4~~: Procedures for Clinical Performance Processes
Appendix: Procedures for Exclusion from Work

~~5.~~4. 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.

~~6.~~5. HSC organisations must notify the Department of the action they have taken to comply with this revised framework by INSERT DATE

Background

~~7.~~6. 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.

~~8.~~7. 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 shortcomings ~~failures~~ in the delivery of care to prevent a re~~o~~ccurrence. Underperformance of healthcare professionals is one of many factors that can impact on the delivery of quality care.

~~9.~~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 practice. This approach recognises the importance of seeking to address ~~clinical~~ performance

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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 this is warranted.~~a situation may warrant this approach.~~

Purpose And Coverage Of The Revised Framework

~~10.~~ This framework ~~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.~~

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~~11.~~9. **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 on a regular basis ~~periodically~~ throughout the investigatory process.**

~~12.~~10. All HSC organisations ~~must~~ have established procedures for handling concerns about an individual's performance. These procedures must reflect those outlined in this framework. ~~and allow for agreed resolution of problems where deemed appropriate.~~

~~13.~~11. This guidance is applicable to all doctors and dentists employed by one of the six 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 Northern Ireland Medical and Dental Training Agency and the NI Blood Transfusion Service. **This guidance does not apply to doctors and dentists who provide services to the HSC but are independent contractors rather than employees.**

~~14.~~ Concerns in relation to the performance of doctors and dentists in training, the standards for which are outlined in the Gold[3] and Foundation[4] guidance ~~should~~, should be managed by employers in line with those for other medical and dental staff. It is, however, essential that the Postgraduate Dean, as Responsible Officer for doctors in postgraduate training programmes, is involved in these cases **from the outset**. The onus still rests with the employer for the conduct of the investigation and any necessary action. The *Managing Concerns Toolkit* contains information from the Deanery on addressing concerns in relation to trainees.

~~15.~~12. Similarly, if t**he Northern Ire**land 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. The organisation will then pursue the concern.

~~16.~~13. Guidance on managing concerns in General Practice has been developed by the DHSSPS; *The Prevention, Detection and Management of Underperformance in General Practice (April 2002)*. If a concern arises in respect of a doctor practising in an HSC Trust who is on the Primary Medical Performers List, the Responsible Officer of the Health and Social Care Board (HSCB) should be informed.

~~17.~~14. Where a case involves allegations of abuse against a child or a vulnerable adult, guidance issued to the HSC in 2006, *Safeguarding Vulnerable Adults* and the revised framework C*hoosing to Protect Children and Vulnerable Adults 2009*

[3] The Gold Guide
[4] Foundation Guide

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should be referred to and advice sought from the organisations' Adult and Child Protection officer .[5]

STRATEGIC CONTEXT OF THIS FRAMEWORK

~~18.~~15. Since 2005 there has been significant restructuring in the HSC, as well ~~as along~~ a number of recommendations for enhanced regulation of healthcare professionals.~~with proposals for new regulatory arrangements for doctors and dentists~~. These,~~is,~~ 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

~~19.~~16. In November 2005, the DHSSPS ~~has~~ implemented a major programme of reform and modernisation in health and social care. The recommendations from the R~~r~~eview of P~~p~~ublic A~~a~~dministration (RPA) in 2002-05 were designed to establish modern, accountable and effective arrangements for public service delivery in Northern Ireland.

~~20.~~17. As their sponsor, the DHSSPS holds all HSC Bodies directly to account for fulfilling their ~~their good governance~~organisational governance responsibilities, of which the guidance and processes outlined in this framework are an element. . This accountability runs through the Minister to the Assembly and its committees.~~s.~~

~~21.~~18. Those responsible within HSC organisations for the implementation of the processes in this framework should be aware of these regional accountability arrangements[6] and ensure that when managing concerns in relation to doctors or

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

[6] http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

Field Code Changed

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.

Commented [JL5]: MB- needs clarified

PROFESSIONAL REGULATION OF DOCTORS AND DENTISTS

~~22.~~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 practise 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[7] and the GMC have published referral thresholds for doctors, which can also be accessed via their website[8].

~~23.~~20. In addition, the GMC has~~ve~~ 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

~~24.~~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 practis~~c~~ing to the standards required by their regulator. Revalidation is a~~n~~ continuous ~~ongoing~~ process that should provide assurance to employers, other healthcare professionals and patients and the public about the performance of doctors and dentists.

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

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

Medical Revalidation And The Responsible Officer

~~25.~~22. The GMC have ~~will~~ implemented ~~a system of~~ revalidation of ~~for~~ its registrants. ~~in late~~ 2012. All registrants with ~~ho~~ 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.

Commented [JL6]: This paragraph will require updating - dependant on publication date revalidation will likely have commenced.

~~26.~~Legislation, (and supporting Guidance)[9] 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[10] identify those ~~HSC~~ organisations that are designated bodies, each of whom has appointed a Responsible Officer. ~~The Northern Ireland Medical and Dental Training Agency is also a designated organisation, making the Postgraduate Dean the Responsible Officer for doctors in training.~~

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~~27.~~23. 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

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

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

~~28.~~24. This framework and associated Guidance contained in the Managing Concerns Toolkit will support the RO in exercising the functions prescribed in regulations outlined above.

Revalidation of ~~For~~ Denti~~st~~al Practicioners s~~

~~29.~~25. The General Dental Council (GDC) has 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. It is prop osed that this assurance would be provided by establishing an 'External ~~verifier~~verifier' who would be required to review the supporting evidence submitted by dentists and certify the individual's compliance with the Professional Standards Framework. These proposals will be subject to ongoing development and potential modification following further consultation.

REVALIDATION AND MANA~~N~~GING CONCERNS

~~30.~~26. 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.

~~31.~~27. A key principle in managing concerns, and in 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.

~~32.~~28. 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 through a robust appraisal system that examines a range of supporting information could allow for earlier intervention and remediation (where appropriate). This will allow practitioners to ~~opportunity to~~ address the area/s identified and provide an opportunity for these to be improved on wherever possible.

IDENTIFYING CONCERNS

What Constitutes a Concern?

~~33.~~29. The majority of practitioners provide a high standard of care to patients. The principles and values which underpin professionalism, and the behaviour required of a doctor or dentist, are described in the GMC's *Good Medical Practice* framework and the GDC's *Professional Standards* framework. As medical and dental practice and technologies evolve, practitioners need to enhance their skills and keep up to date, in order to remain fit to practise. They must also comply with their contractual obligations and the standards expected of them by their employers/s.

~~34. In the course of their professional career every practitioner will experience variation in the level of their practice, and clinical competence. Every practitioner will make mistakes and, on occasion, patients will come to harm as a result. All practitioners must therefore be vigilant in recognising, and taking responsibility for mistakes and for reductions in the quality of their practise. Learning from these will improve patient safety in the future.~~

~~35.~~30. A concern about practice can be said to have arisen where a single ~~n incident~~ incident occurs that causes or has the potential to cause, harm to a patient, staff or the organisation; or where the ~~practitioner develops~~practitioner develops a

pattern of repeating mistakes, or appears to persistently behave in a manner inconsistent with standards required and expected both by their regulator and their ~~employer.~~employer. Concerns can arise in respect of a practitioner's behaviour, conduct or probity and t ~~T~~here will be varying ~~different~~ levels of severity in the concerns identified, as described in Table 1 of this Guidance. Careful analysis of the severity of the concern will guide an appropriate response.

How Concerns May Come to Light

~~36.~~31. The management of staff performance is an organisational ~~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 and addressed 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 should lessen ~~decrease~~ the ~~likelihood~~ likelihood ~~of the need~~ for an extensive investigation and/or implementation of disciplinary procedures.

~~37.~~32. 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.

~~38.~~ 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 for the most part ~~frequently~~ show that these can be attributed to systems or organisational shortcomings. ~~failures~~, ~~or demonstrate that the adverse event was an untoward outcome which could not have been predicted and is not the result of any individual or systems failure.~~

~~39.~~33. When a concern has been raised 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 [JL7]: Check Policy/DW PCC

Raising a Concern about a Colleague

~~40.~~34. There is 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*[11] (2007~~),~~), which details the action programme in response to the Shipman inquiries and lessons learnt from the Ayling and Kerr/Haslam cases.

~~41.~~35. Each professional regulatory body defines standards of practice and behaviours they expect from their registrants, all of which include the requirement to take action if they perceive a risk to patient safety. Therefore, if a regulated healthcare professional does not report or take appropriate action to report or

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

address a risk to patient safety, they will be in breach of their regulatory standards of practice. ~~Thus,~~ As such, there is an additional burden on health care staff subject to statutory regulation to report concerns.

~~42.~~36. All HSC organisations are required to ensure that they have a *Whistle Blowing*[12] policy and should ensure that an employee who wishes to raise a concern about a colleague is supported to do so.

~~43.~~37. Concerns raised about a colleague must, however, be based on concern for patient and / or staff welfare or the continuity of safe service provision within the ~~.~~organisation. 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.

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SUMMARY OF KEY ACTIONS NEEDED WHEN A CONCERN ARISES

~~44.~~38. When a concern is raised, and throughout the resulting processes, equal consideration should be given to both the investigation of the concern and action/s needed to ensure patient and public safety and maintain public ~~.~~ confidence. As such, the key actions needed at the outset can be summarised as follows:

- undertake a preliminary investigation to clarify the problem or concern
- ~~-~~review findings of preliminary investigation and identify next steps
- ~~-~~
- consider if immediate ~~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

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[12] http://www.dhsspsni.gov.uk/hss f 07 - 2009 whistleblowing.pdf

- consider if action is required to protect any potential evidence
- consider who should be informed of the concern
- consider necessity of completing an ~~Serious~~ Adverse Incident proforma.

~~46.~~39. Decision making in respect of what action should be taken when a concern is identified can be informed by the use of a categorisation framework. This tool may support organisations to ensure that a consistent and defined methodology is applied as part of its M*anaging Concerns* policy.

~~47.~~40. An example framework is given below; it should be noted that escalation between the levels of categorisation should be clearly defined and that the level of concern may change at different points in the process as further information becomes available.

Table 1: Categorisation Framework

Low Level Indicators	Moderate Level Indicators	High Level Indicators
Could the problem have been predicted?		
Unintended or unexpected incident		
What degree of interruption to service occurred?		
Incident may have interrupted the routine delivery of accepted practice (as defined by professional regulator) to one or more persons working in or receiving care		Significant incident which interrupts the routine delivery of accepted practice (as defined by professional regulator) to one or more persons working in or receiving care
How likely is the problem to reoccur?		
Possibility of reoccurrence but any impact will remain minimal or low. Recurrence is not likely or certain	Likelihood of recurrence may range from low to certain	Likelihood of recurrence may range from low to certain
How significant would a recurrence be?		
	Low level likelihood of recurrence will have a moderate impact (where harm has resulted as a direct consequence and will have affected the natural course of planned treatment or natural course of illness as is likely or certain to have resulted in moderate but not permanent harm) Certain level likelihood of recurrence will have a minimal or low impact.	Low level likelihood of recurrence will have a high impact (where severe/permanent harm may result as a direct consequence and will affect the natural course of planned treatment or natural course off illness such as a permanent lessening of function, including non-repairable surgery or brain damage)
How much harm occurred?		
No harm to patients and the doctor is not vulnerable or at any personal risk No requirement for treatment beyond that already planned	Potential for harm to staff or the doctor is at personal risk A member of staff has raised concerns about an individual which requires discussion and an action plan.	Patients, staff or the doctor have been harmed

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What reputational risks exist?		
Organisational or professional reputation is not at stake but the concern needs to be addressed by discussion with the practitioner	Organisational or professional reputation may also be at stake	Organisational or professional reputation is at stake
Does the concern impact on more than one area of practice?		
Concern will be confined to a single area of Good Medical Practice/ Professional Standards for Dentists May include one of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	Concern affects more than one area of Good Medical Practice/ Professional Standards for Dentists May include one or more of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	May include a serious adverse incident or complaint requiring a formal investigation This includes criminal acts and referrals to the professional regulator
Which factors reduce the level of concern?		
	De-escalation from moderate to low: Reduction to low or minimal impact Reduction in the likelihood of recurrence Evidence of completion of effective remediation	De-escalation from high to moderate: Reduction in impact to moderate Reduction in the likelihood of recurrence Evidence of insight and change in practice

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Which factors increase levels of concern?		
Escalation from low to moderate: Increase in impact to moderate Likelihood of recurrence is certain No evidence of insight or change in practice	Escalation from moderate to high: Increase in impact to severe Increase in likelihood of recurrence No evidence of remorse, insight or change in practice	
How much intervention is likely to be required?		
Insight, remorse and change in practice will be evident Remediation is likely to achieved with peer support The practitioner has no other involvement in incidents or has outstanding or unaddressed complaints The remediation plan should take no longer than four weeks to address	Insight, remorse and change in practice may be evident Remediation is likely to achieved with specialist support The remediation plan should take no longer than three months to address	Remediation will only be achieved through specialist support The remediation plan will take upwards of three months and may include a planned period of supervised practice

PROTECTING PATIENTS AND THE PUBLIC

48.41. A risk assessment should be undertaken by a senior manager (with advice from a senior clinician) ~~likely to be the RO/MD)~~ 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.

49.42. The risk assessment should include consideration of the ~~the~~ need to share information with another organisation. As discussed in paragraph14, 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. If the concern relates to a General Practitioner, the RO of the Regional HSCB should be informed.

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50.43. The organisation will also wish to consider at this stage, and throughout any subsequent investigation, the need to initiate any of the following actions, guidance on which is contained in the *Managing Concerns Toolkit*:

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- Patient Service Reviews/ Look Back Exercise
- Requesting the issue of a Chief Medical Officer Alert Letter
- The need to initiate the DHSSPS Early Alert Protocol
- The need to complete an ~~Serious~~ Adverse Incident Report

- The need to communicate a Patient Safety Incident with Patients, Families and their Carers

SECTION 3: INVESTIGATION

~~51.~~44. This section outlines the key principles and best practice in undertaking an investigation of a concern.

~~52.~~45. Good practice in carrying out investigations of concerns can be summarised in the following principles, [13]:

- The overriding objective should be to protect the safety of patients and the public and to maintain public confidence
- 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 where possible
- Roles and responsibilities in relation to the investigation should be clearly defined
- Investigations should be adequately resourced
- Organisations must work to agreed timescales and practitioners must respond to reasonable requests from their employer/s
- 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 when necessary, including occupational health assessment, recording when they have done so and how it has contributed to decision making.

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

UNDERTAKING AN INVESTIGATION

~~53.~~46. 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.~~ investigation**. It is expected that a significant number of concerns will be resolved following a preliminary investigation. Actions that may be taken during and on completion of each type of investigation are described later ~~further on~~ in this Guidance.

~~54.~~47. It should be noted that if the practitioner is the subject of an ongoing investigation by the Police, the Counter Fraud and Probity Services (CFPS)[14] or a regulatory/ licensing body, this does not necessarily prevent an investigation into unrelated matters taking place. It would however, be advisable to consult the relevant organisation before commencing any investigation, for example the GMC's Employment Liaison Advisor. If an investigation has been commenced and the organisation becomes aware of another investigation, liaison with the relevant body should take place.

~~55.~~48. 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.

~~56.~~49. The following principles from the Labour Relations Agency [15] provide 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

[14] http://www.hscbusiness.hscni.net/services/Counter%20Fraud%20and%20Probity%20Services.htm
[15] http://www.lra.org.uk/index/agency_publications-2/advice_and_guidance_on_employment_matters-3/advisory_guides2/advice_on_conducting_employment_investigations.htm