FAO Dr Fitzpatrick
Practitioner Performance Advice
NHS Resolution
8th Floor
10 South Colonnade
Canary Wharf
London
E14 4PU

5 October 2022

Dear Sir

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

Provision of a Section 21 Notice requiring the production of a Witness Statement & Documents

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

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

Section 21 Notice

You will be aware that the Inquiry has started its investigations into the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant statements and documentation from relevant departments, organisations and individuals.

In keeping with the approach we are taking with other departments, organisations and individuals, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of a further witness statement from you.

This Notice is issued to you given your role within Practitioner Performance Advice (hereafter referred to as PPA), formerly The National Clinical Assessment Service

(NCAS) and following receipt of your Witness Statement and Supplementary Witness Statement dated 22 March 2021 and 6 July 2022 respectively which were received in response to Section 21 Notice 52/2022 served on the PPA. It relates to documents within the custody or control of the PPA department and requires written responses to questions posed. The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. It is hoped that this Section 21 Notice will alleviate any concerns that your department may have in relation to data protection or confidentiality.

As the text of the Section 21 Notice explains, you are required by law to comply with it.

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

You will also note several references to documents referenced to this Notice (e.g. at Para's 2, 3 & 6).These documents are Inquiry 'BATES Referenced' documents. BATES referencing is the Inquiry's pagination system whereby the source of the document is recorded and a number attributed to the document depending on the order in which it was received e.g. WIT 41278, which is a Witness Statement and is the 41,278th page of Witness statements received to date. Please speak to your legal advisor concerning these documents.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

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

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

Arrangements for Oral Evidence

I note from paragraph 3 of your Supplementary Witness Statement that you are due to re-locate to Personal Information redacted by the USI in November 2022. You will appreciate that, given the Terms of Reference, the Inquiry may require oral evidence from you in the future.

Given the current timeframes for Inquiry, it is not envisaged that you will be required to give oral evidence prior to your expected departure in November 2022.

The Inquiry would be prepared to put reasonable adjustments in place, primarily by the provision of live link facilities, to enable you to give oral evidence from abroad. However, the Inquiry would be seeking an express written undertaking from you that you will assist the Inquiry and provide oral evidence from abroad should this be required. I would be grateful if this undertaking could be provided as soon as ever possible.

Further to the above, the Inquiry would require to provide your contact details for when you are abroad, including an email and correspondence address.

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 104 of 2022]

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

WARNING

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

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

TO: FAO Dr Colin Fitzpatrick
Practitioner Performance Advice (PPA)
NHS Resolution
8th Floor
10 South Colonnade
Canary Wharf
London
E14 4PU

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 16th November 2022.**

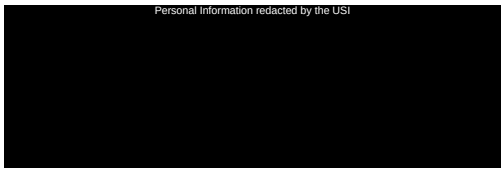
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **12.00 noon on 9th November 2022**.

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

Dated this day 5th October 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 104 of 2022]

Concerns

1. At paragraph 8 of your Supplementary Witness Statement dated 6 July 2022 you state as follows:

"*It occurs to me that there were a number of missed opportunities by the Trust with Dr O'Brien's case. Initially when Simon Gibson telephoned me on 7 September 2016, I recall asking if there were wider concerns with regards to Dr O'Brien's capability and I was told that there were not. My observation is that Simon Gibson cannot have been fully informed at the time he contacted me because find it difficult to believe that there were not prior concerns about capability before this call took place. Anecdotally I understand there are individuals who worked with Dr O'Brien who had concerns about his capability for a long time. I do not have any documentary evidence that these concerns were ever formally raised.*"

With regard to your awareness of any concerns about Mr. O'Brien's capability, address the following questions:

a) Outline all information which you have received or been made aware of at any stage that led you to conclude that there were pre-existing concerns about Mr. O'Brien's capability.
b) When, in what circumstances and from what source was this information received?
c) Which, if any, of Mr. O'Brien's colleagues had been identified as having any such concerns?
d) What action, if any, did you take upon receiving this information to ensure that patient safety was protected?
e) When and in what circumstances was this information, if at all, brought to the attention of any of the following:

    i. The Medical Director in the South Health and Social Care Trust ("the Trust") acting as Mr. O'Brien's Responsible Officer;

ii. Practitioner Performance Advice;
iii. The Department of Health;
iv. The GMC;
v. Or any other relevant person or body.

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance ("the 2010 Guidelines")

2. Outline what advice was provided by NCAS to the Trust during the drafting of the 2010 Guidelines, having particular regard to (WIT- 41278), an email from Vivienne Toal to Siobhan Hynds dated 14 August 2010, attached for ease of reference, and any advice concerning the role of the Oversight Group. Provide copies of all relevant documentation relating to same.

3. Outline what training you provided to the Trust in September 2010 with regard to the 2010 Guidelines and the role of NCAS, having regard to (WIT-41325 – 41345), attached for ease of reference.

4. Outline what if any advice was offered by NCAS which led to or contributed to the Trust Guidelines being updated in 2018.

Training

5. The Inquiry understands that you were responsible for delivering a 'Case investigator training workshop' to managers from the Trust on 7 – 8 March 2017. With regard to this training:

i. Outline the names and roles of those in attendance;
ii. Outline the topics covered and specific training or advice offered;
iii. Disclose a copy of any slides or training resources relied upon.

Updates or Reviews of MHPS

6. Having regard to (WIT-43152), an email from Dr Woods to yourself dated 24 November 2011, attached for ease of reference, outline the nature and extent of your involvement in a review of the Maintaining High Professional Standards in the Modern HPSS Framework ("MHPS") conducted by the Department of Health between 2011 and 2013 and in particular address the following points:

    a. Outline the circumstances which led to you contributing to the review of MHPS conducted by the Department, including who asked for your input and when were you asked.
    b. Outline the full extent of your involvement in the review including any actions taken, documents reviewed or correspondence sent.
    c. Outline what issues you understand were identified with MHPS during the course of the review.
    d. Outline what you understand to have been the outcome of the review of MHPS conducted by the Department of Health between 2011 and 2013.
    e. If you understand that no action was taken or amendments made to MHPS following the review of MHPS conducted by the Department of Health at that time, explain the reasons why you understand that no action was taken following the review.

7. If you have been involved in any other review of MHPS, conducted by the Department of Health or otherwise, outline the nature and extent of your involvement in same and in particular address the points identified in sub-paragraphs 6 (a) – (e) above.

NOTE:

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

Toal, Vivienne

From: Vivienne Toal <[redacted]>
Personal Information redacted by the USI
Sent: 14 August 2010 10:36
To: Siobhan Hynds
Subject: MHPS HR Version VT August 2010
Attachments: MHPS HR Version VT August 2010.docx

Siobhan

Please see attached MHPS procedure.

When you are talking to Kieran can you ensure he is happy with role of Oversight Group in that they are endorsing the decision of the Clinical Manager as to action to be taken. In light of NCAS formal advice I think this is safe enough and they can have a sufficient challenge function.

Also will you check with him about copying it to LNC - just in case it gets off on wrong footing because they haven't been advised of the document and the roles that individuals will play.

There is definitely room for more cross referencing of the procedures to the MHPS framework and best practice guidance - will you have a look to see if more references can be entered?

Finally - will you read through to make sure I have not stated anything that is not correct i.e. goes against MHPS framework.

Sorry to dump this on you - but hopefully this gets the bulk of the text done.

Before sharing with Kieran - will you run it past Debbie, and then send to Kieran with copy to Anne and Debbie. Let Kieran send it on to Mairead and Debbie once he is happy with it.

Thanks

Vivienne

Toal, Vivienne

From: Brennan, Anne <Personal Information redacted by the USI>
Sent: 16 September 2010 14:26
To: colin.fitzpatrick Personal Information redacted by the USI
Cc: Donaghy, Kieran; McAlinden, Mairead; Loughran, Patrick; Hynds, Siobhan; Toal, Vivienne
Subject: Medical Leadership Network: 16.09.2010
Attachments: agenda_24sept2010-revised16sept2010.doc; Procedure for Handling Concerns about Doctors and Dentists Performance (MHPS) FINAL 15 September 2010.doc

Dear Colin –
Thank you very much for agreeing to lead the training afternoon on 24th September. I explained that this is part of an Associate Medical Director/Clinical Director Medical Leadership training programme and we are concentrating on performance concerns for doctors and dentists. In terms of the timetabled programme I can confirm that after the introductions and background we can give you about 1 hour to talk about the work of NCAS. I enclose the draft of our guidance in relation to this subject and following your presentation – as discussed, two senior members of our HR team will go through the principles within the guidance and how it links to maintaining high professional standards. After a short break we can then work through the 5 scenarios and expect to be finished around 4.30 I look forward to hearing to seeing you on the 24th.

Regards, Paddy

Anne Brennan

Southern Health & Social Care Trust

Tel Personal Information redacted by the USI
Personal Information redacted by the USI
www.southerntrust.hscni.net

Southern Health and Social Care Trust

Southern Health and Social Care Trust
Medical Leadership Network

Friday 24th September 2010 at 1.30pm
Venue: Board Room, Trust Headquarters, Craigavon Area Hospital

Purpose:
This session provides an opportunity to explore how we handle performance concerns about doctors and dentists.

Programme

1.30 Welcome and Introductions – Christine McGowan

1.40 Background to Workshop Event – Dr P Loughran

1:50 NCAS – Dr Colin Fitzpatrick

2:50 Southern Trust Guidance on Handling Concerns about Doctors and Dentists – V Toal/S Hynds

3.10 Break

3:30 Case Studies via Group Work:

Scenario 1:
The Coroner expresses concern that an elective Aortic Aneurysm case was poorly managed resulting in the death of the patient. The Trust has been asked to look at the doctors competence. He is recently appointed. You are the AMD what action would you expect the Trust to take?

Scenario 2:
A member of the multidisciplinary team contacts you as AMD to express concern about the competency of a doctor who carries out procedures. They advise you that

they have already raised the concern with the Clinical Director who feels that no action is required. What steps do you take to address the team members concern?

Scenario 3

Your colleague and close friend turns up for work and smells strongly of alcohol. He explains that he was at a party the previous night. He insists that he is capable of working today. You know him well and you do not agree. What actions do you take? Does the Trust have policies to assist?

Scenario 4

In audit of antibiotic prescribing there is one paediatric nephrologist who does not follow the Trusts published antibiotic guidance. You are the Clinical Director – how would you manage this situation?

Scenario 5

The Trust's quarterly report which looks at Clinical Indicators suggests that there is an excess of morbidity in one doctors' practice [large number of admissions to ICU]. What actions should the Medical Director, Operational Director and AMD take?

4.30 Review and Close

In preparation for the workshop attendees have been sent a copy of the **Trust Guidance on Handling Concerns about Doctors and Dentists** to consider. If you have not received a copy of this, please contact Laura White at [redacted] a copy will be forwarded to you.

Personal Information redacted by the USI

Southern Health and Social Care Trust

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

FINAL

15 September 2010

1.0 Introduction

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

1.2 The MHPS framework is in six sections and covers:

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

1.3 MHPS states that each Trust should have in place procedures for handling concerns about an individual's performance which reflect the framework.

1.4 This procedure, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk for patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:

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

1.5 This guidance also seeks to take account of the new role of Responsible Officer which Trusts in Northern Ireland must have in place by October 2010 and in particular how this role interfaces with the management of suspected poor medical performance or failures or problems within systems.

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

1.7 This procedure should be read in conjunction with the following documents:

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005

Annex B
"How to conduct a local performance investigation" NCAS, 2010

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

2.0 SCREENING OF CONCERNS – ACTION TO BE TAKEN WHEN A CONCERN FIRST ARISES

2.1 NCAS Good Practice Guide – "How to conduct a local performance investigation" (2010) indicates that regardless of how a is concern in identified, it should go through a screening process to identify whether an investigation in needed. The Guide also

indicates that anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

2.2 Concerns should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 MHPS (2005) states that **all** concerns must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

2.4 The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager within Employee Engagement & Relations Department prior to undertaking any initial verification / fact finding.

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

2.6 The Clinical Manager and the nominated HR Case Manager will be responsible for investigating the concerns raised and assessing what action should be taken in response. Possible action could include:

- No action required
- Informal remedial action with the assistance of NCAS
- Formal investigation
- Exclusion / restriction

The Clinical Manager and HR Case Manager should take advice from other key parties such as NCAS, Occupational Health Department, in determining their assessment of action to be taken in response to the concerns raised. Guidance on NCAS involvement is detailed in MHPS paragraphs 9-14.

2.7 Where possible and appropriate, a local action plan should be agreed with the practitioner and resolution of the situation (with involvement of NCAS as appropriate) via monitoring of the practitioner by the Clinical Manager. MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather than solely through formal action. However, it is not intended to weaken accountability or avoid formal action where the situation warrants this approach. The informal process should be carried out as expediously as possible and the Oversight Group will monitor progress.

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

2.9 The Chief Executive will be informed of the action to be taken by the Clinical Manager and HR Case Manager by the Chair of the Oversight Group.

2.9 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager

and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

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

Appendix 1
An informal process. This can lead to resolution or move to:

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

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

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

Appendix 5
Exclusion can be used at any stage of the process.

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or

recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

3.3 If the findings following informal or formal stages are anything other than the practitioner being exonerated, these findings must be recorded and available to appraisers by the Clinical Manager (if informal) or Case Manager (if formal).

3.4 All formal cases will be presented to SMT Governance by Medical Director and Operational Director to promote learning and for peer review when the case is closed.

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

Appendix 1

Step 1 Screening Process

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

→

Clinical Manager/Operational Director informs:

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

↓

Chief Executive appoints an Oversight Group – usually comprising of:

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

↓

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

↓

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

↓

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

→ No Action Necessary

→ Informal remedial action with assistance and input from NCAS

→ Formal Investigation

→ Exclusion / Restriction

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

Appendix 1

Step 2 Informal Process

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

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

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

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

Referral to NCAS

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

Appendix 2

Formal Process

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

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

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

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

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

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

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

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

Case Manager must then make a decision on whether:

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

Appendix 3

Conduct Hearings / Disciplinary Procedures

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

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

↓

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

↓

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

↓

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

↓

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

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

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

Case reviewed by SMT Governance for action / learning points.

Appendix 3a

Clinical Performance Hearings

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

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

↓

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

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

↓

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

↓

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

↓

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

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

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

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

Appendix 3a

Clinical Performance Hearings

During the hearing:

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

During the hearing - witnesses:

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

During the hearing – order of presentation:

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

Decision of the panel may be:

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

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

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

Case reviewed by SMT Governance for action / learning points.

Appendix 4

Appeal Procedures in Clinical Performance Cases

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

Composition of the panel – 3 people:

- **Chair**

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

- **Panel 1**

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

- **Panel 2**

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

Advisors to the Panel:

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

Timescales:

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

Powers of the Appeal Panel

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

Documentation:

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

Appendix 5

Restriction of Practice / Exclusion from Work

- All exclusions must only be an interim measure.
- Exclusions may be up to but no more than 4 weeks.
- Extensions of exclusion must be reviewed and a brief report provided to the Chief Executive and the Board. This will likely be through the Clinical Director for immediate exclusions and the Case Manager for formal exclusions. The Oversight Group should be informed.
- A detailed report should be provided when requested to the designated Board member who will be responsible for monitoring the exclusion until it is lifted.

Immediate Exclusion

Consideration to immediately exclude a Practitioner from work when concerns arise must be recommended by the Clinical Manager (Clinical Director) and HR Case Manager. A case conference with the Clinical Manager, HR Case Manager, the Medical Director and the HR Director should be convened to carry out a preliminary situation analysis.

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

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

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

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

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

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

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion

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

↓

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

→

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

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

↓

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

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

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

If the decision is to exclude the Practitioner:

↓

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

→

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

↓

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

→

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

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

This is the person to whom concerns are reported to. This will normally be the Clinical Director or Associate Medical Director (although usually the Clinical Director). The Clinical Manager informs the Chief Executive and the Practitioner that concerns have been raised, and conducts the initial assessment along with a HR Case Manager. The Clinical Manager presents the findings of the initial screening and his/her decision on action to be taken in response to the concerns raised to the Oversight Group.

Chief Executive

The Chief Executive appoints an appropriate Oversight Group and is kept informed of the process throughout. (The Chief Executive will be involved in any decision to exclude a practitioner at Consultant level.)

Oversight Group

This group will usually comprise of the Medical Director / Responsible Officer, Director of Human Resources & Organisational Development and the relevant Operational Director. The Oversight Group is kept informed by the Clinical Manager and the HR Case Manager as to action to be taken in response to concerns raised following initial assessment for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

Formal Process

Chief Executive

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

Case Manager

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

Case Investigator

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

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

Non Executive Board Member

Appointed by the Trust Chair, the Non-Executive Board member must ensure that the investigation is completed in a fair and transparent way, in line with Trust procedures and the MHPS framework. The Non Executive Board member reports back findings to Trust Board.

Roberts, Naomi

From: Woods, Paddy
Sent: 24 November 2011 09:10
To: Colin Fitzpatrick
Cc: Lindsay, Jane
Subject: RE: Review of Maintaining High Professional Standards in NI

Colin

Thanks for this.

We will take account in revising documentation.

Regards

P

From: Colin Fitzpatrick [mailto: Personal Information redacted by the USI
Sent: 23 November 2011 07:49
To: Woods, Paddy
Subject: Review of Maintaining High Professional Standards in NI

Paddy,

Further to our recent discussion regarding your review of MHPS, we have a few comments to make.

First, we agree that MHPS would benefit from revision as experience since it was issued has identified a number of areas for improvement. However, we are concerned that awareness of the document and its provisions is not as widespread within HSC managers as we would have hoped. The experience of our advisors is that we frequently have to remind managers of the provisions and processes within MHPS.

A particular concern is the notification and review of exclusions as described in section II. We find that we are generally consulted before exclusion, although this may be after the trust has already made the decision. We are also concerned that regular reviews may not always occur, in particular the formal referral back to NCAS at the third review. I do not know whether the six month report to the Department occurs. It may be that we should have a discussion about how well this process is working.

Section IV, paragraph 7 would benefit from rewording, in particular the part relating to performance which is fundamentally flawed.

I should point out that we find the wording of Section IV, paragraph 2 to be an improvement on its English equivalent.

The description of NCAS and its services would also benefit from revision.

Finally, we feel that the word informal in the flow diagram on page 43 to be counterproductive. We have found that this encourages an overly relaxed attitude to process and could be replaced by another term such as preliminary.

Colin

Dr Colin Fitzpatrick,
Lead NCAS Advisor (Northern Ireland)

National Clinical Assessment Service (NCAS N I)
Office Suite 3
Lisburn Square House
10 Haslem's Lane

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 104 of 2022

Date of Notice: 5 October 2022

Supplementary Witness Statement of Colin Fitzpatrick

I, Colin Fitzpatrick will say as follows:-

1. I make this further supplemental statement in order to address some further issues highlighted by the Statutory Independent Inquiry into the Urology Services in the Southern Health and Social Care Trust (the Inquiry), since my witness statement of 6 July 2022. This statement has been prepared with reference to the case file, my earlier witness statement and my own knowledge of the operation of the NCAA/NCAS/ The Advisory Service/Practitioner Performance Advice.

2. I re-locate to [redacted] and commence full-time as a GP on 1 November 2022.

3. My earlier witness statements of 22 March 2021 and 6 July 2022 remain factually correct.

Anecdotal Concerns in relation to Dr O'Brien's Capability

4. At paragraph 8 of my Supplementary Witness Statement dated 6 July 2022, I refer to there being "*individuals who worked with Dr O'Brien who had concerns about his capability for a long time*". This anecdotal information surrounding Mr O'Brien's capability was received after he had ceased practise. The source was a (now) very senior doctor in Northern Ireland who had worked with Mr O'Brien as a trainee. The informal comments were made at a meeting about something entirely unrelated. I wish to emphasise that it was a casual conversation that took place around the time that there was media coverage regarding Dr O'Brien.

5. I did not take any action given that it was a passing comment and that Dr O'Brien was not in practice when the conversation took place. I believe that he had either already retired or had been suspended by the General Medical Council. I do not

have access to my diary from this time, in order to put a date on the conversation. I did not bring the anecdotal information to the attention of any relevant person or body.

Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance ("the 2010 Guidelines")

6. I have been provided with a copy of **WIT41278**, together with documents **WIT41325-41345** and I am asked to outline what training I provided to the Trust in 2010 with regard to the 2010 Guidelines and the role of NCAS. At exhibit **[CF10],** I produce the slides from this training I delivered on 24 September 2010 entitled *"National Clinical Assessment Service – helping resolve performance concerns*". The training was a raising awareness event, where NCAS contributed to an external event hosted and managed by the Trust.

7. I produce an email at exhibit **[CF11]** which describes how and why NCAS were asked to deliver this training and a further email at **[CF12]** containing informal feedback following the training from Paddy Loughran, the then Medical Director at the Trust.

8. I cannot recall providing advice to the Southern Trust on either their original 2010 guidelines or the 2018 revision. If the formal advice from NCAS referenced can be provided, this might jog my memory. NHS Resolution have reviewed files and are unable to locate anything where NCAS were asked to contribute as part of the training to the updating of the Trust guidelines.

Case Investigator Training 7 – 8 March 2017

9. I have been asked to provide further information with regard to a Case Investigator Training Workshop that I delivered to managers from the Trust on 7 – 8 March 2017. This workshop was commissioned specifically by the Trust. This was an off the shelf package, meaning the materials were used universally throughout Northern Ireland at that time (developed from a product used in England and Wales). I would have delivered this training around 10 times per year across the UK designed to investigate performance issues and the training was very well-received. This was practical training for the investigators giving delegates a feel for how to investigate and how to draft a report. MHPS states that case investigators should be suitably trained and this was why the training was developed.

10. In this particular training session, an additional session was added at the Trust's request on Day 2 "*Support for case investigators including top tips from experienced AMDs at Southern Health & Social Care Trust*".

11. A copy of the delegate programme outlining the learning objectives, pre-reading, programme, learning methods and NCAS' Statement of Principles is produced at **[CF13].** I facilitated the workshop, together with my former colleague, Grainne Lynn. The presentation slides for day one on 7 March 2017 are produced at **[CF14]** and day two on 8 March 2017 are produced at **[CF15]**. An accompanying email dated 18 February 2018 from the Programme Executive in External Education at NHS Litigation Authority attaching the delegate programme and presentation slides is produced at **[CF18 now CF16].**

12. The delegate names, job titles and organisations are produced at exhibit **[CF17]** and the sign in sheet is produced at exhibit **[CF18].**

13. I also produce as exhibits various training materials from the Case Investigator Training Workshop. It should be noted that these are the English version that have subtle differences and given that they are slightly adapted year on year, they are not the exact materials delivered in March 2017. Whilst it is acknowledged that there may be some subtle differences, they are broadly the same and are indicative of content and learning points:

    a. **[CF19]** – Workshop A;

    b. **[CF20]** – Workshop B1;

    c. **[CF21]** – Workshop B2;

    d. **[CF22]** – Workshop C1;

    e. **[CF23]** – Workshop C2;

    f. **[CF24]** – Workshop C3;

    g. **[CF25]** – Workshop C4;

    h. **[CF26]** – Workshop C5;

    i. **[CF27]** – Workshop C6;

    j. **[CF28]** – Workshop C7;

k. **[CF29]** – Workshop C8;

l. **[CF30]** – Workshop C9;

m. **[CF31]** – Workshop C10;

n. **[CF32]** – Workshop C11;

o. **[CF33]** – Workshop D;

p. **[CF34]** – Workshop E;

q. **[CF35]** – Workshop F;

r. **[CF36]** – Workshop G; and

s. **[CF37]** – An action planning form providing to delegates.

14. I produce at **[CF38]** a copy of the evaluation report dated May 2017 which provides a summary, next steps and evaluation feedback from the delegates who attended the training.

Updates or Reviews of MHPS

15. I have been provided with a copy of **WIT-41352,** an email from Dr Woods dated 24 November 2011. I am asked to outline the circumstances which led me to contribute to the review of MHPS conducted by the Department, including who asked for my input and when was I asked. As an organisation, NHS resolution have been trying to undertake various searches of my email account during that period, without success as the period in question precedes NHS Resolution joining the (then) NHSLA.

16. As I can remember, the **WIT-41352** email followed an informal discussion with Paddy Woods and I believe that this was my only contribution to the review of MHPS. I believe that Dr Woods convened a group shortly after a meeting took place and I was not invited to join this group. The MHPS document remains the same as when it was originally written. I was not involved in a review, any actions taken, documents reviewed or correspondence sent. Whilst it perhaps should have been, I am unaware of any action that was taken as a result of a review of MHPS conducted by the Department of Health between 2011 and 2013.

Urology Services Inquiry

17. I am not aware of any other review of MHPS by the Department of Health or otherwise.

18. I am willing to give oral evidence at the Inquiry by video link from [redacted] assuming that adequate notice is given and a that convenient time can be agreed.

Statement of Truth

I believe t[redacted] this witness statement are true.

Signed: [redacted]

Date: 20 October 2022

Bundle/ Exhibit number	Date	Document Title	Document Description
	20/10/2022	Third Witness Statement of Colin Fitzpatrick	
1. **CF10**	Undated	CF10 Presentation ALL FINAL	Presentation titled 'The National Clinical Assessment Service - helping resolve performance concerns' presented by Colin Fitzpatrick
2. **CF11**	19/04/2010	CF11	Email from Jill Devenney to Colin Fitzpatrick re MHPS training
3. **CF12**	27/09/2010	CF12	Email from Jill Devenney to Kerri Deegan and NCAS Education with Colin Fitzpatrick copied in and Email from Laura White to Colin Fitzpatrick re Medical Leadership Programme
4. **CF13**	07/03/2017 – 08/03/2017	CF13	Case Investigator Training Workshop – Objectives and Programme
5. **CF14**	Undated	CF14	Presentation titled 'Case Investigator Training Secondary Care Day 1'
6. **CF15**	Undated	CF15	Presentation titled 'Case Investigator Training Secondary Care Day 2'
7. **CF16**	28/02/2017	CF16	Email confirming final details of Case Investigator Training workshop
8. **CF17**	Undated	CF17	Table of delegates with their job titles and organisations
9. **CF18**	Undated	CF18	Sign in Sheet

10. **CF19**	Undated	CF19 - CISC Workshop A 190520	Case Investigator Training Workshop Workshop A: Exploring the issues England / Secondary Care DELEGATE VERSION
11. **CF20**	Undated	CF20 – CISC Workshop B.1 190520	Case Investigator Training Workshop Workshop B.1: Critiquing Terms of Reference (Dr Violet) England / Secondary Care DELEGATE VERSION
12. **CF21**	Undated	CF21 – CISC Workshop B.2 190520	Case Investigator Training Workshop Workshop B.2: Critiquing Terms of Reference (Dr Purple) England / Secondary Care DELEGATE VERSION
13. **CF22**	Undated	CF22 – Workshop C Index of Evidence log	Case Investigator Training Workshop Index of Evidence – England/ Secondary Care DELEGATE VERSION
14. **CF22**	Undated	CF22 – CISC Workshop C.1 ToR 190520	Case Investigator Training Workshop Workshop C.1: Critiquing Terms of Reference England / Secondary Care DELEGATE VERSION
15. **CF23**	Undated	CF23 – CISC Workshop C.2 SHARPS POLICY 190520	Case Investigator Training Workshop Workshop C.2: Sharps policy England / Secondary Care DELEGATE VERSION
16. **CF24**	Undated	CF24 – CISC Workshop C.3 NICE 190520	Case Investigator Training Workshop

			Workshop C.3: NICE guidelines England / Secondary Care DELEGATE VERSION NICE guidelines on disposing of sharps directly
17. **CF25**	Undated	CF25 – CISC Workshop C.4 DIGNITY AT WORK 190520	Case Investigator Training Workshop Workshop C.4: Dignity at work policy England / Secondary Care DELEGATE VERSION
18. **CF26**	Undated	CF26 – CISC Workshop C.5 INC FORM NDL STCK 190520	Case Investigator Training Workshop Workshop C.5: Incident form (Needle stick) England / Secondary Care DELEGATE VERSION
19. **CF27**	Undated	CF27 – CISC Workshop C.6 Patient Patterned Complaint 190520	Case Investigator Training Workshop Workshop C.6: Patient Patterned complaint England / Secondary Care DELEGATE VERSION Complaint letter from patient dated 18/11/16
20. **CF28**	Undated	CF28 – CISC Workshop C.7 Dr Orange to Dir. Med Ed 190520	Case Investigator Training Workshop Workshop C.7: Dr Orange to Dir. Med Ed - complaint England / Secondary Care DELEGATE VERSION Complaint from trainee dated 19/11/2016
21. **CF29**	Undated	CF29 – CISC Workshop C.8 Dir Med Edu Complaint 190520	Case Investigator Training Workshop

			Workshop C.8: Dir. Med Ed to Dr Maroon - complaint England / Secondary Care DELEGATE VERSION
22. **CF30**	Undated	CF30 – CISC Workshop C.9 INC FORM VSCLR ACCSS 190520	Case Investigator Training Workshop Workshop C.9: Incident form (Vascular access) England / Secondary Care DELEGATE VERSION
23. **CF31**	Undated	CF31 – CISC Workshop C.10 INC FORM PACEMAKR 190520	Case Investigator Training Workshop Workshop C.9: Incident form (Pacemaker) England / Secondary Care DELEGATE VERSION
24. **CF32**	Undated	CF32 – CISC Workshop C.11 CHRCTR REF 190520	Case Investigator Training Workshop Workshop C.11: Dr Purple character reference England / Secondary Care DELEGATE VERSION
25. **CF33**	Undated	CF33 – CISC Workshop D OBS FORM 190520	Case Investigator Training Workshop Workshop D: Interview skills practice England / Secondary Care DELEGATE VERSION
26. **CF34**	Undated	CF34 – CISC Workshop E OBS FORM 190520	Case Investigator Training Workshop Workshop E: Interview skills practice England / Secondary Care

			DELEGATE VERSION
27. **CF34**	Undated	CF34 – CISC Workshop E SELF REFL 190520	Case Investigator Training Workshop Workshop E: Interview skills practice England / Secondary Care DELEGATE VERSION Self-Reflection Form
28. **CF35**	Undated	CF 34 – CISC Workshop F Report Writing SECONDARY v6 190520	Case Investigator Training Workshop Workshop F - Investigation of Dr Purple - (Secondary Care) Report Writing
29. **CF36**	Undated	CF 36 – CISC Workshop G RESPND TO CHALL draft 190520	Case Investigator Training Workshop Workshop F - Investigation of Dr Purple - (Secondary Care) Report Writing
30. **CF37**	Undated	CF 37 – Action Planning form v1 FINAL	Personal and Organisational Action Planning Form
31. **CF38**	Undated	CF38 Evaluation Report	Case Investigator Training Workshop Evaluation Report

The National Clinical Assessment Service

- helping resolve performance concerns

Colin Fitzpatrick

Lead NCAS Adviser (Northern Ireland)

National Clinical Assessment Service

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National Clinical Assessment Service

Overview

- What we do and why we do it
- What we have seen
- What we offer
- What about the future?

What we do

- Support to local resolution of concerns about the practice of doctors, dentists and pharmacists
  - Casework
    - Expert support – to local case management
    - Comprehensive service – from telephone call to action plan
  - Education
    - Building front-line ownership and expertise
    - Making practical tools and resources available
  - Evaluation, research and development
    - Improving our work and methods
    - Sharing our learning and experience
- Coverage
  - Across the UK and associated states
  - Public and independent sectors
  - Self-referral
  - Free at the point of delivery

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Why we do it

- Public protection, patient safety and public assurance
  - 900-1000 referrals yearly – small population with disproportionate impact on public confidence
  - Cases coming earlier – 83% less than a year old in 2008/09, compared with 36% in 2002/03
- Impact
  - Suspension/exclusion – down by 80% and average length down by 33% since 2003 – estimated annual saving >£10million (National Audit Office)
  - Cases – two-thirds of most serious cases back in work after remediation
  - Complaints and litigation – earlier, better handling of performance failure
  - Reduction in high profile cases and resulting public inquiries
- Building the profile of professional governance
  - Service extension by invitation – from doctors in the NHS in England, to three professions, three sectors and seven jurisdictions
  - Collaborations across Europe, North America, Australia and New Zealand
  - Assessment methods seen as ‘industry standard’

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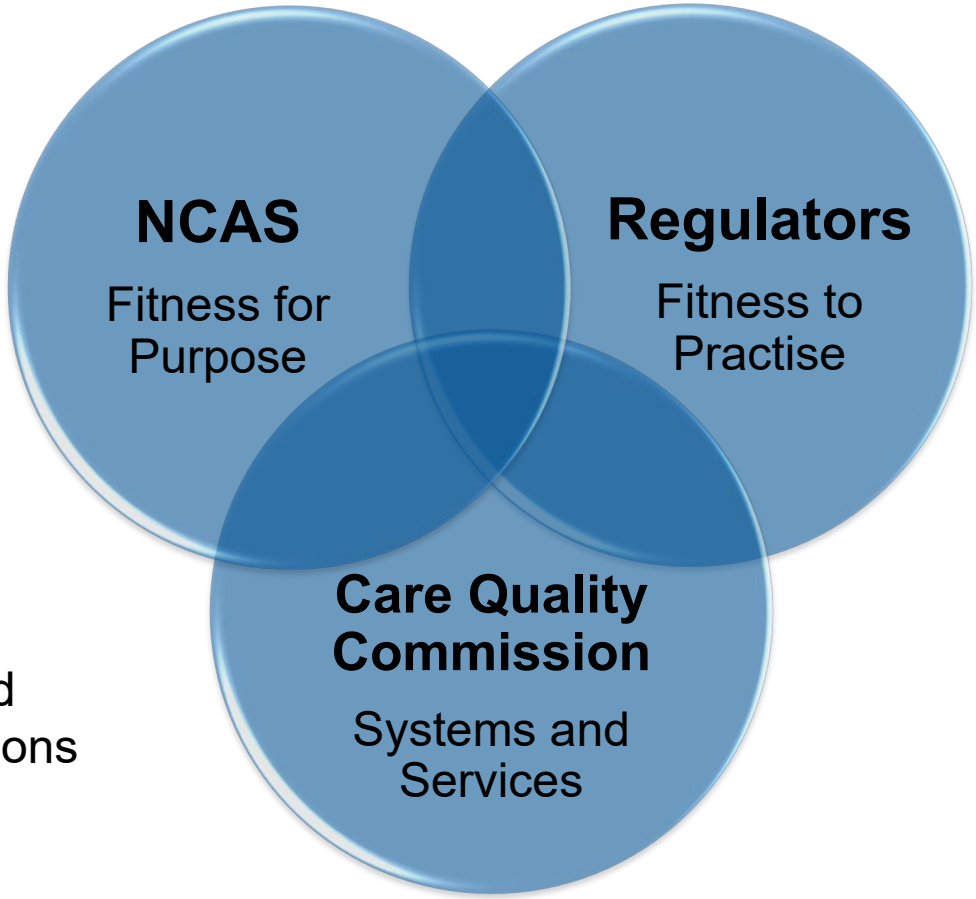
Where we fit – partners and stakeholders



Royal Colleges

Deans and Universities

Professional Associations and Defence Organisations

Health Care Management

Health Care Performance Management

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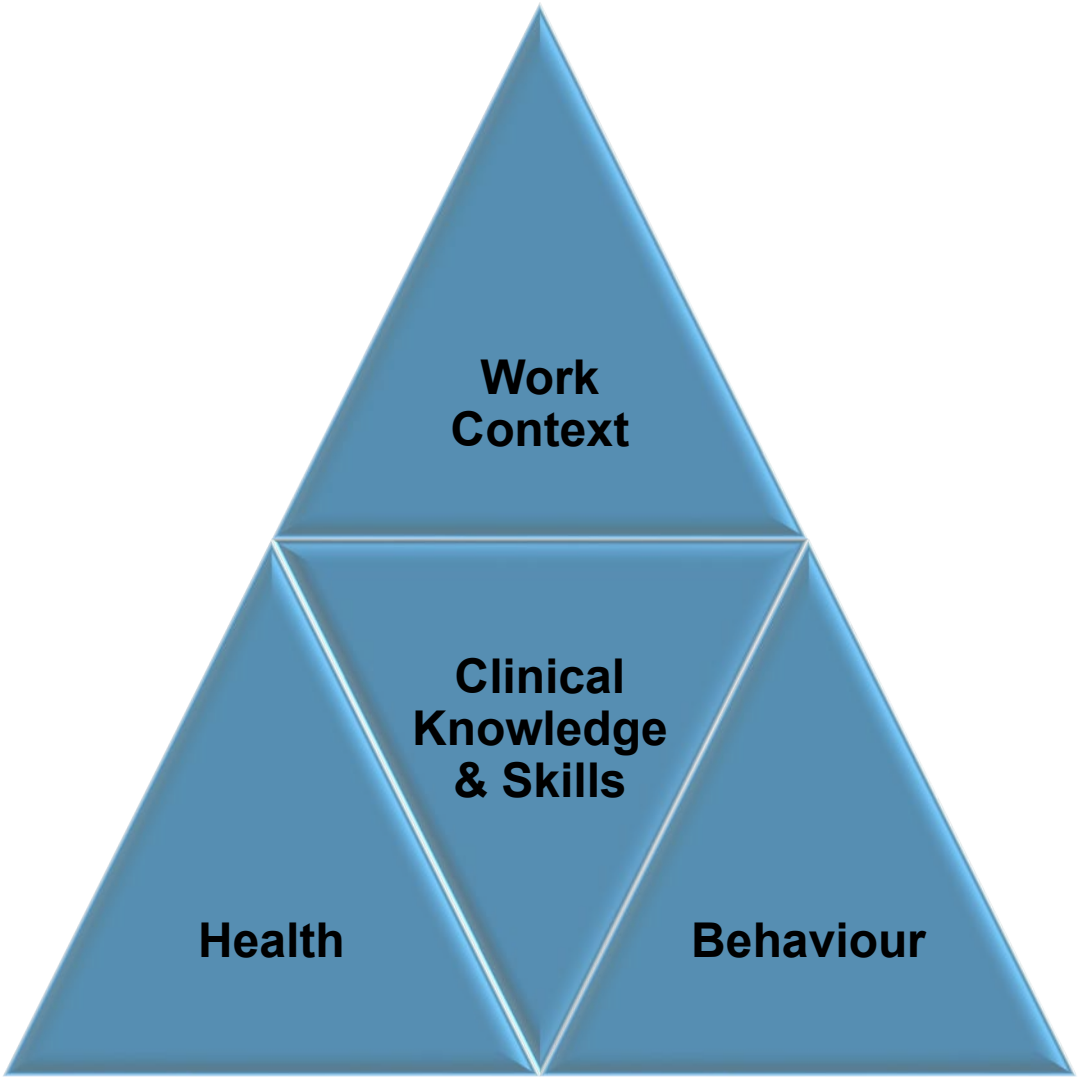
The Performance Triangle – our 'take' on the Canadian model



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The picture now – who contacts us and why

- 1 doctor in 200 and 1 dentist in 250 referred to NCAS each year
  - 900-1000 referrals yearly
  - 3 in 4 NHS organisations refer at least once a year
  - More than half working with us at any time
  - Used equally, regardless of type or 'organisational rating'
  - Small but consistent self-referral rate – about 3%
  - Overlap with professional regulators very small
- Certain groups more likely to be referred
  - Older
  - Consultants – and career grades more generally
  - Men
  - In secondary care, non-white doctors qualifying outside the UK
  - Substantially more likely for single-handed than in practices of 4 or more

The picture now – what we find

- NCAS' experience in assessing practitioners
  - 82% have five or more major areas of deficit across four domains
  - 94% have significant difficulty arising from their approach to working with colleagues
  - 88% have major challenges arising from their working environment
- What we find is often at variance with what is notified at referral

Domain	Notified at referral*	Found at assessment**
Clinical skills	54%	82%
Governance and safety	35%	48%
Behaviour – conduct	33%	
Behaviour – other than conduct	29%	94%
Health	24%	28%
Organisational	11%	88%

* Source: NCAS: *NCAS Casework – The first eight years, 2009*

** Source: NCAS, *Analysis of the first 50 assessment cases, 2005*

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Contacting NCAS – what happens?

- Initial contact
  - Usually CE or relevant Director (HR, MD, DPA or PA) will call – someone carrying decision-making authority of referring body (RB)
  - 020 7062 1620 – advice and support service
  - Brief details of the case given and a time agreed for NCAS Adviser call-back – RB decides the priority and timing of the call-back
- Detailed telephone discussion with Adviser – letter confirms advice
- If not resolved following Adviser call-back
  - Round-table meeting(s) between Adviser and relevant parties
  - Further advice – case continues to be locally handled or referred for NCAS assessment
  - In all cases - continuing support from NCAS as required

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NCAS Cases – how do we define them?

- Advice and support cases – about 90%
  - Two thirds – telephone advice on a one-to-one basis with its focus more on the use of local or national systems and processes and less on the details of the particular practitioner
  - One third – more detailed support work with referring body and practitioner aimed at resolving a performance dispute between an organisation and one of its practitioners
  - Nature of the performance concern must be clear – or irrelevant to the handling of the case
- Assessment and action planning – up to 10%
  - Where specialist diagnostic work is needed to get behind the concern

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NCAS Assessment

- Independent view on the performance of the practitioner within the wider context of their practice
- Challenge
  - Create a developmental model in an adversarial environment
  - Credible, robust to challenge, affordable and practicable
- Models
  - Full performance assessment – developmental, holistic approach across all domains: clinical skills, behaviour, health, work context
  - Clinical performance assessment – under contract to regulator
- Method
  - Peer clinical, behavioural, lay assessors, trained & quality assured
  - Structured gathering of information across the scope of practice
    - Direct observation
    - Record review
    - Questions based on own clinical practice
    - Views of colleagues and patients

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In Summary – NCAS as part of your governance arrangements

- A central resource to supplement and support individual governance arrangements
- Drawn from the collected – and collective – experience across the whole UK and internationally
- Independent – offering verification and challenge
- An educational and developmental resource for managers and practitioners
- Free at the point of need

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Developments into the future?

- NCAS' role in revalidation and recertification
  - Supporting the development of Responsible Officers (ROs)
  - Local focused review where concerns are identified
  - Guiding and focusing how remediation can be taken forward

Supporting the development of Responsible Officers

- Portfolio of workshops which draw on NCAS' experience including
  - Conducting investigations
  - Overseeing investigations
  - Handling behavioural concerns
  - Handling health concerns
  - Use of local performance procedures
  - Supporting remediation
- Online materials
- Publications

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NCAS Local focused review

- Need for a limited review of practice to determine whether a full diagnostic assessment is required
  - Sampling and review of (15-20) clinical records in areas where concerns are identified
  - Structured interview with practitioner around clinical knowledge and decision-making in relation to notes reviewed
  - Report for practitioner and referrer

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Guiding remediation

- Support to devise an action plan using a standard template
- Base on review/assessment to define the concerns
- Advice on access to resources (courses, placements, 1:1)
- Facilitate meetings with relevant parties, e.g. Board, NIMDTA, RCGP

IN THIS SECTION

« Toolkit
- Managing
- Developing
- Alerting
- Supporting
- Documenting
- Investigating
- Rebuilding
- Disciplining
- Toolkit feedback
- Feedback

Toolkit

NCAS Toolkit

Although it looks like the rest of the NCAS website, this is a separate section with its own navigation system so the top menu has changed. You can get back to the main NCAS site at any time, via 'Home'.

The Toolkit is written as a resource for NHS managers. Click on a heading and you see a list of ideas, with menus underneath which take you to:

- Practice – putting the idea to work
- Cases – practical examples based on anonymised NCAS casework
- Resources – tools that might help, such as links to relevant legislation, NCAS briefings, model policies

This is a filing system for ideas. It isn't a crisis management tool. If you have an immediate concern about the performance of a doctor, dentist or pharmacist, phone us on **020 7062 1655** (England) , **029 2044 7540** (Northern Ireland or Wales) or **0131 220 8060** (Scotland).

If you need a short cut to the key regulations governing doctor and dentist performance, use Must Knows.

Please read this important note (pdf 36kb) before using the toolkit.

Toolkit sections

Managing
Developing
Alerting
Supporting
Documenting
Investigating
Rebuilding
Disciplining

NCAS and NCAS-Related Resources

- www.ncas.npsa.nhs.uk, including
  - Must knows www.ncas.npsa.nhs.uk/resources/mustknows
  - Publications www.ncas.npsa.nhs.uk/publications
  - Toolkit www.ncas.npsa.nhs.uk/toolkit
  - NCAS Resource www.ncas-resource.npsa.nhs.uk
- Practitioner Health Programme www.php.nhs.uk

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National Patient Safety Agency

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Understanding factors that affect performance

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Factors that impact on performance

- Individual:
  - Clinical knowledge and skills
  - Health and stress
  - Psychological factors
  - Leadership skills.
- Organisational:
  - Education and training – undergraduate and postgraduate
  - Organisational culture and climate
  - Team functioning
  - Workload and sleep loss.

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Understanding performance difficulties in doctors

An NCAA report
November 2004

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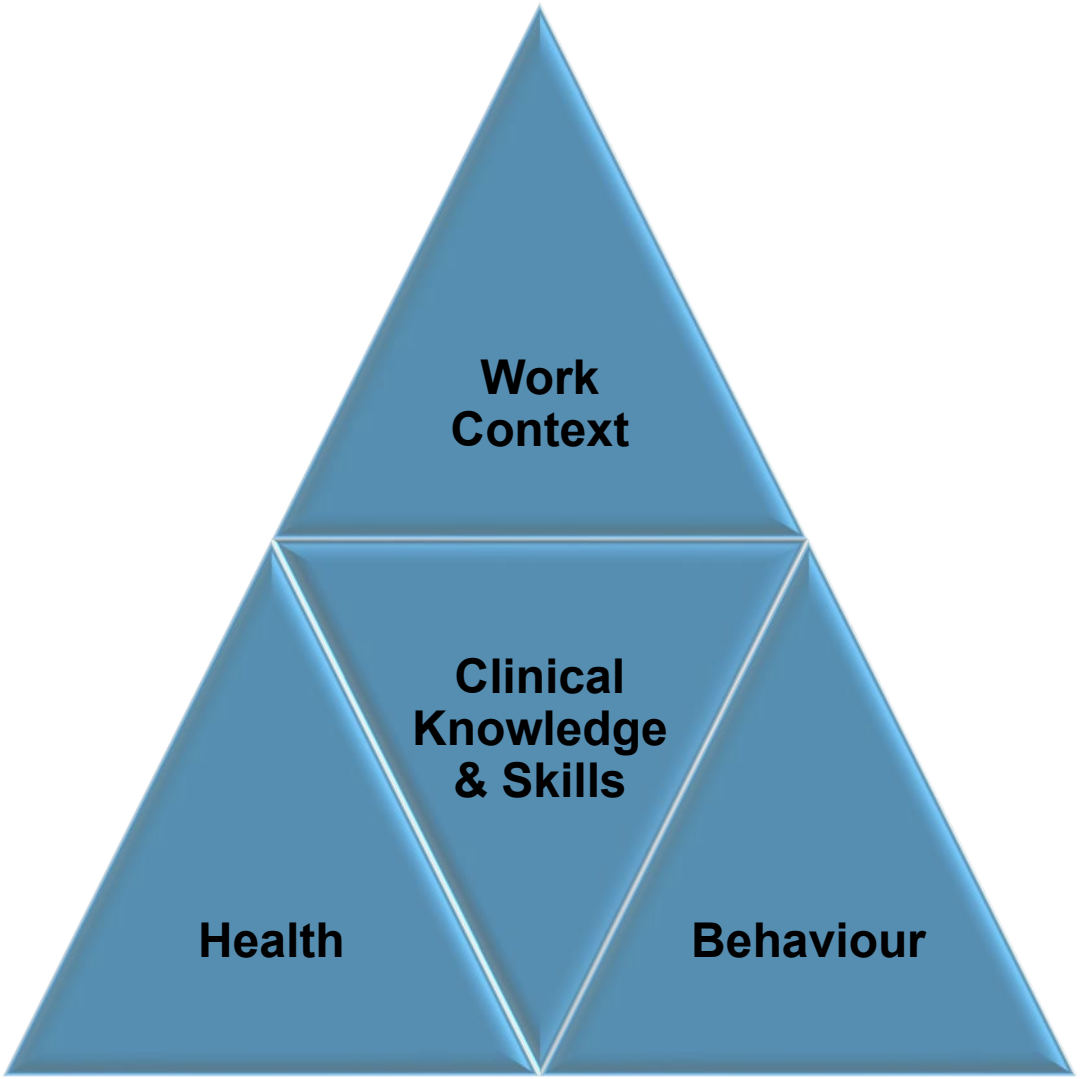
The performance triangle



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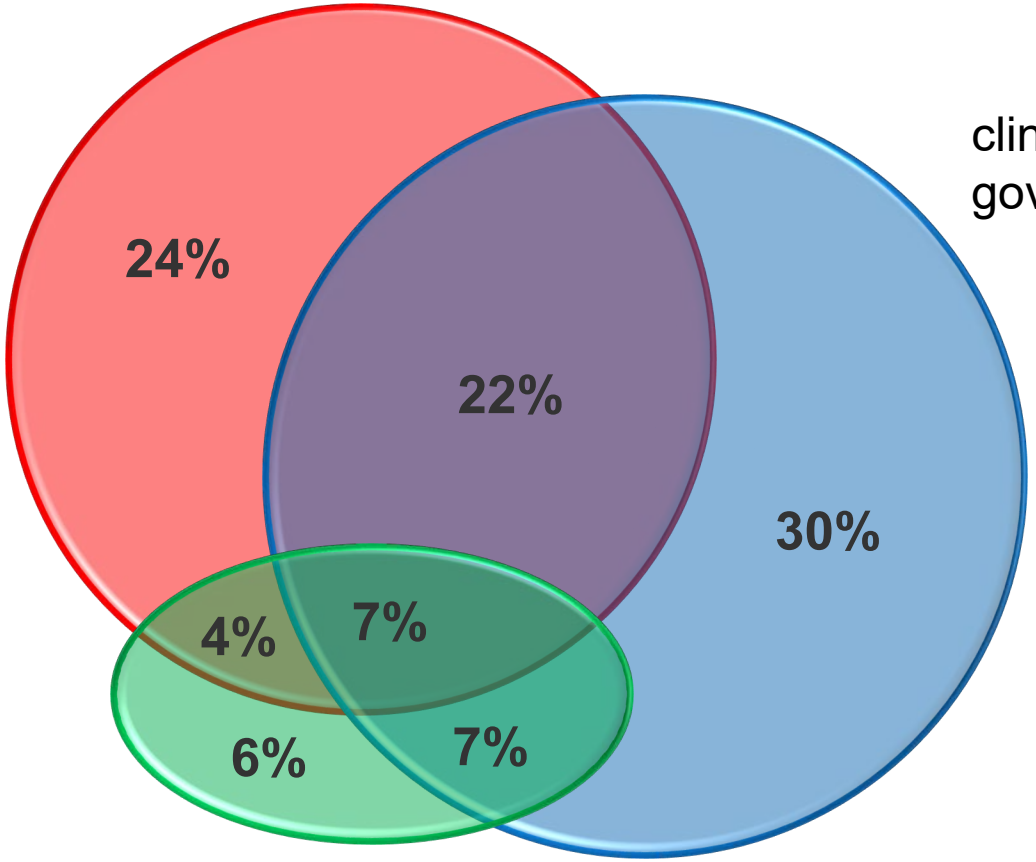
What concerns come forward

behaviour / misconduct – 56%



clinical concerns including governance / safety 65%

health concerns 24%

sample = 1472 cases handled by NCAS Dec 2007 – Mar 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 behaviour

- Aggressive behaviour – 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]

Behavioural factors – how strengths can become weaknesses

STRENGTH	DYSFUNCTIONAL BEHAVIOUR
Enthusiastic	Volatile
Shrewd	Mistrustful
Independent	Detached
Focused	Passive-Aggressive
Confident	Arrogant
Charming	Manipulative
Vivacious	Dramatic
Imaginative	Eccentric
Diligent	Perfectionist
Dutiful	Dependent

Source: Hogan and Hogan (1997); King (2008)

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Behavioural factors – summary preliminary findings

- Patient-focused to the exclusion of wider considerations
- Diligent to the point of perfectionism
- Confrontation-averse
- Poor influencers
- Low self-awareness
- Receptive to ideas
- **BUT** resistant to changing their own ways of working

Source: King (2007) content analysis of 176 NCAS cases

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What predicts the likelihood of change?

- Do they have the 'key' personality traits to help them change?
  - Are they stable enough?
  - Can they persevere?
- Do they have insight?
  - Are they psychologically minded?
  - Can they reflect on their behaviour and learn from their experience?
- Do they want / intend to change?
  - Have they a history of successful change attempts?
  - What will motivate them to change?
- What kind of environment will they be working in?
  - What support is available?
  - What are the contextual factors that may influence their behaviour?

Source: King (2008)

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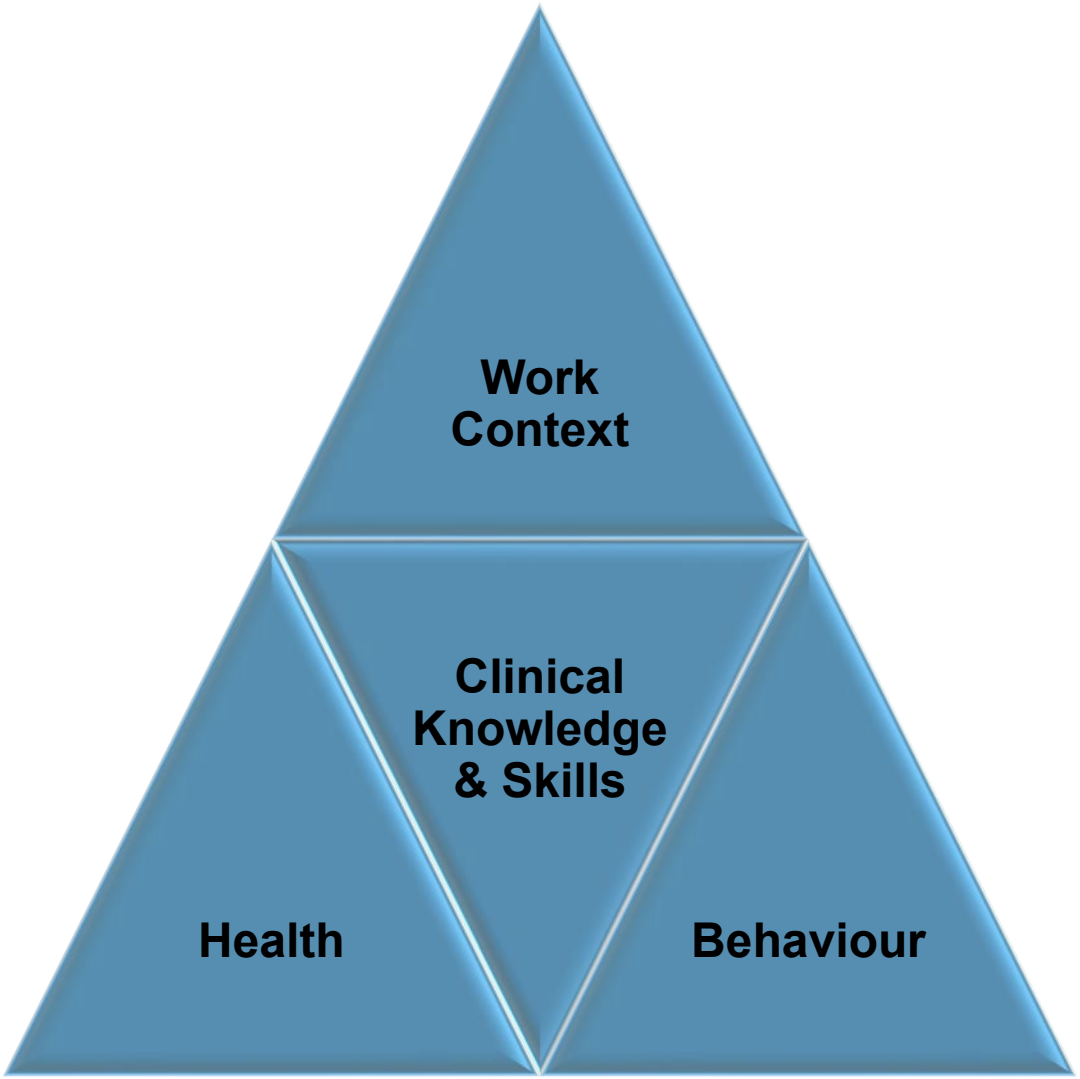
The performance triangle



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Clinical knowledge and skills - Analysis of 50 assessment cases

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

Factors notified at referral and found at assessment:

Domain	Notified at referral*	Found at assessment**
Clinical performance	54%	82%
Governance and safety	35%	48%
Behaviour – conduct	33%	n/a
Behaviour – other than conduct	29%	**94%**
Health	24%	28%
Organisational	11%	**88%**

* Source: *NCAS Casework – The first eight years, 2009*

** Source: NCAS, *Analysis of the first 50 assessment cases, 2005*

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Getting behind the concern – the organisation

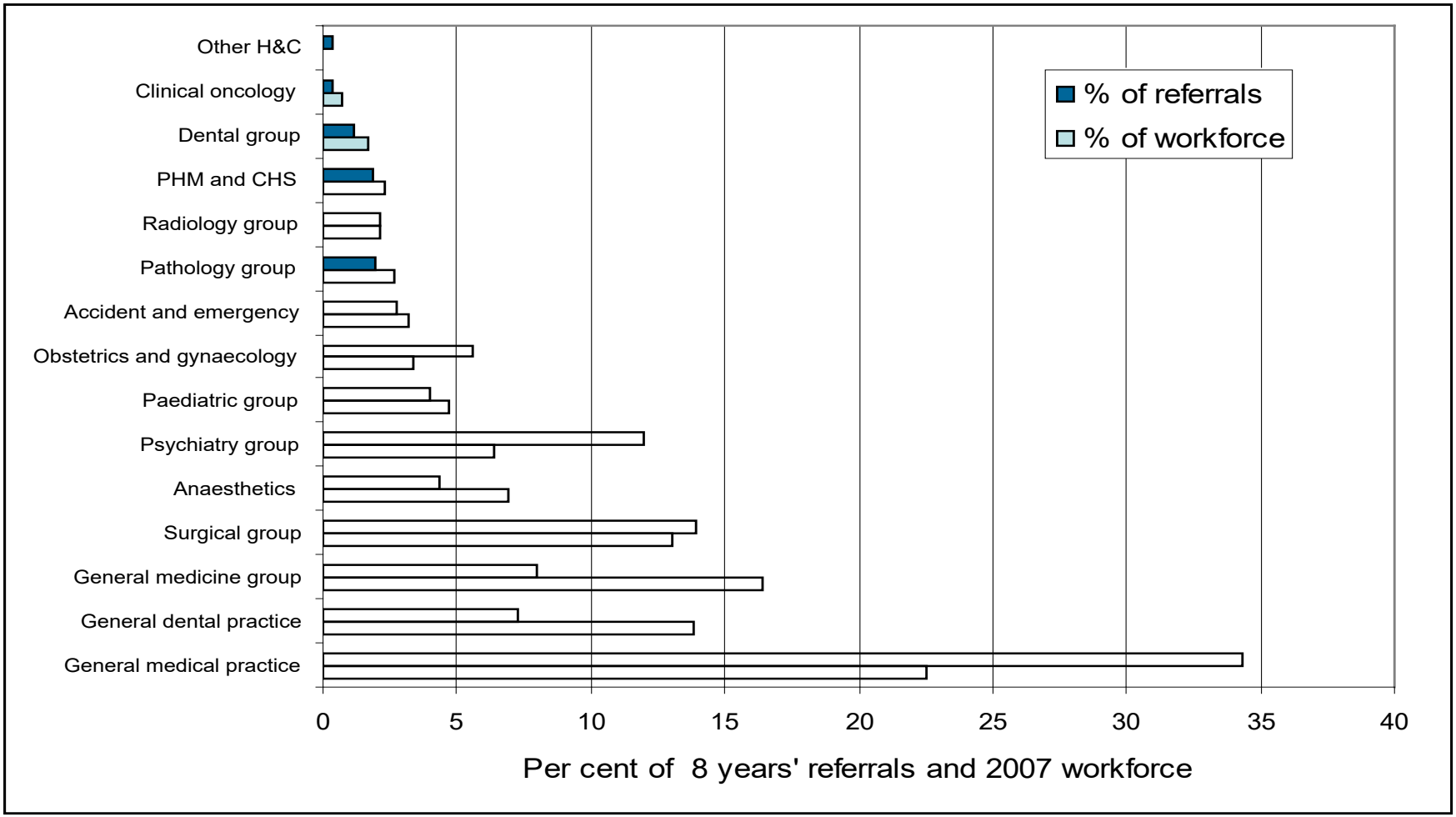
- Workload – pressure on individual
- Difficulties in the team
  - Ineffective leadership
  - Inadequate clinical or administrative support
  - Unclear roles, poor morale
- Tolerance of disruptive behaviour

Other factors that may affect performance – learning from referral patterns

Certain groups are more likely to be referred

- Older practitioners
- Consultants and other career grades
- Men
- In secondary care, doctors with an overseas qualification
- Single-handed GPs (compared with those in practices >4 doctors)

Specialty distribution of referrals and workforce



F8Y Chart 2.1

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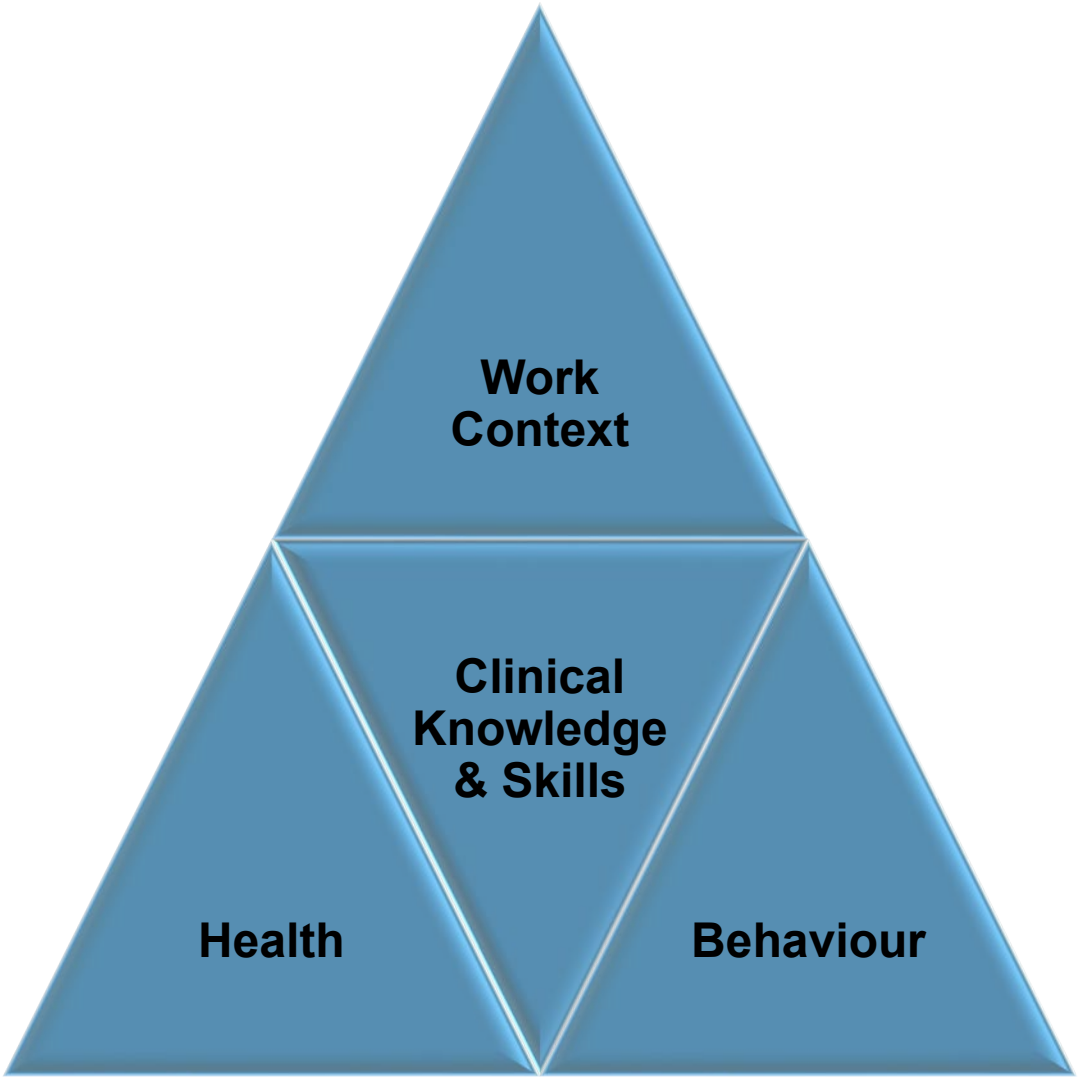
The performance triangle



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Further reading

- NCAS publications www.ncas.npsa.nhs.uk/publications
- Article of the analysis of the first 50 NCAS assessment cases – *Journal of Health Organization and Management,* October 2007
- *Understanding doctors' performance* – booklet and book
- Practitioner Health Programme www.php.nhs.uk

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The National Clinical Assessment Service

- helping resolve performance concerns

Colin Fitzpatrick

Lead NCAS Adviser (Northern Ireland)

National Clinical Assessment Service

NHS
National Clinical Assessment Service

Chloe Williams

From: [redacted]

Sent: 19 April 2010 14:00
To: Sandra Reid
Cc: Kiu Nghiem
Subject: FW: Request for MHPS training for medical staff, Southern Health and Social Care Trust, N I

Follow Up Flag: Follow up
Flag Status: Flagged

FYI

Jemima Cooper

Education & Support Services
National Clinical Assessment Service

From: Jill Devenney
Sent: 19 April 2010 12:10
To: Colin Fitzpatrick; Grainne Lynn; NCAS Education
Subject: Request for MHPS training for medical staff, Southern Health and Social Care Trust, N I

Colin

Re: Maintaining Health and Professional Standards

Had a phone call from Heather Ellis, Education Learning and Development, Southern Health and Social Care Trust (tel: [redacted]).

Heather told me about a new initiative (medical leadership network base) within the Southern Trust. Paddy Loughran, Southern Trust Medical Director, is keen to secure NCAS input at an event they are planning to hold on Friday 24 September 2010 in the pm.

Southern Trust is offering NCAS a 2 hour slot and would like:

- presentation to Associate Medical Directors and Clinical Directors (approx 20 people)
- Heather thought a question and answer session about maintenance of high professional standards would be good
- information/key issues to assist Assoc Med Dirs and Clinical Directors who will then cascade to their directorates
- information to help to ensure Trust is meeting health and professional standards appropriately
- an up-to-date picture re MHPS, NCAS etc

Southern Trust would welcome discussions about content and cost. (Initial contact for this would be Heather.)

Please come back to me if you foresee any difficulties with this or if you need further information etc.

Thanks

Jill

JILL DEVENNEY
NCAS N I Adviser Administrator
National Clinical Assessment Service (NCAS N I)
Office Suite 3 (please note our new office suite no)
Lisburn Square House
Haslem's Lane
Lisburn BT28 1TW

DIRECT LINE: Personal Information redacted by the USI
FAX: Personal Information redacted by the USI **(please note new fax line no)**

EMAIL: Personal Information redacted by the USI
WEBSITE: www.ncas.npsa.nhs.uk

Chloe Williams

From: Jill Devenney [Irrelevant redacted by the USI]

Sent: 27 September 2010 11:11
To: Kerri Deegan; NCAS Education
Cc: Colin Fitzpatrick
Subject: FW: Medical Leadership Programme

Dear Kerri and NCAS Education Team

Colin and I received this email from Paddy Loughran this morning in response to the Southern Trust MHPS event on Friday afternoon.

As you can see from his email, Paddy was appreciative of the preparation that had gone into the event, the standard of the training, participants' feedback, outcome etc.

Big "thank you" to Kerri and the Education Team for all the hard work behind the scenes. It does not go unnoticed.

Much appreciated!

Best wishes

Jill

-----Original Message-----
From: White, Laura [mailto[Personal Information redacted by the USI]]
Sent: 27 September 2010 10:54
To: Colin Fitzpatrick
Cc: Jill Devenney; McAlinden, Mairead; Wright, Elaine
Subject: Medical Leadership Programme

Dear Colin

Thank you very much for leading our training event on Friday 24th September. Informal feedback was excellent. The preparation which you put into the event and your wealth of experience was invaluable.

It was obvious to me that the participants enjoyed the afternoon and as the scenarios played out the engagement by all, and the standard of the responses, demonstrated that the preparation/training had been excellent.

I had a conversation with the Chief Exec later on Friday evening and she was very pleased with the outcome.

I am very grateful for your help.

Best wishes

Paddy

Ms Laura White

Personal Assistant to

Dr Patrick Loughran

Medical Director

Southern Health & Social Care Trust

FIRBANK HOUSE

Craigavon Area Hospital

68 Lurgan Road

PORTADOWN

BT63 5QQ

Tel: Personal Information redacted by the USI

Fax: Personal Information redacted by the USI

E-mail: Personal Information redacted by the USI >

P Please consider the environment before printing this e-mail.

National Clinical Assessment Service

Case investigator training workshop

For Southern Health and Social Care Trust

Tuesday 07 – Wednesday 08 March 2017

09:15-16:45 (Day 1) and 09:00-16:00 (Day 2)

Seagoe Parish Centre, 46 Seagoe Road, Portadown, Co. Armagh, BT63 5HW

DELEGATE PROGRAMME

This two-day workshop has been designed specifically for anyone who undertakes the case investigator role in investigations about practitioners, which may emerge from the processes underpinning revalidation or from concerns raised about performance. The workshop is interactive and uses case studies to explore and develop the key skills and knowledge required by case investigators.

Learning objectives
By the end of the two-day programme, delegates will be able to:

- Explore how concerns about a practitioner's practice arise and identify the most common factors affecting performance
- Explain why the decision to investigate is made and suggest other options to resolve performance concerns
- Describe roles and responsibilities of those involved in investigations
- Plan for an investigation which meets national requirements
- Describe the principles of robust and meaningful terms of reference and know how to work within them
- Collect, review and weight evidence
- Conduct an investigative interview using a structured approach
- Recognise the key skills and attributes of a case investigator
- Recognise their own limits of competence and access sources of support and expertise
- Reference relevant national/local standards
- Write an investigation report with conclusions
- Describe the potential legal challenges to an investigation.

Pre-reading
Questions to consider prior to attending the workshop:

- What is the role of the Case Investigator?
- When might an investigation of a concern be necessary?
- What is the purpose of an investigation?

Programme

This programme is indicative of the content areas which will be covered. Timings are flexible and will be tailored to focus on areas of particular interest to delegates.

Facilitators: Dr Colin Fitzpatrick, Senior Adviser (NI) and Dr Grainne Lynn, Adviser, National Clinical Assessment Service

DAY 1

08:45-09:15 *Registration and refreshments*

09:15 Welcome, introductions and overview of the workshop

09:35 **Dealing with concerns about a practitioner's practice:**

- Performance concerns
- Overview of investigations
- Frameworks for managing concerns:
  - MHPS
  - PLR
  - Organisational policies
- Workshop A: Dealing with concerns about a practitioner's practice.

10:45-11:00 *Break and refreshments*

11:00 **Investigation roles and responsibilities:**

- Case investigators
- Case managers
- Responsible officers
- Decision making groups
- Other stakeholders/parties, including clinical experts
- Supporting the practitioner.

11:30 **Starting the investigation:**

- Linking with the case manager
- Terms of reference
- Planning the investigation
- Principles of investigation
- Bias and prejudice (perceptions and reality).

12:00-12:45 *Lunch*

12:45 **Workshop B: Critiquing terms of reference and responding to a case manager's request.**

13:45*	**Gathering evidence:** • Sources of potential evidence • Evidence log • Documentary evidence • Evidence/comments from the practitioner • National and peer standards and guidance • Weighting and judging evidence • Workshop C: Investigation of Dr Purple – review of documentary evidence. **Refreshments available from 15:15*
15:45	**Gathering evidence:** • Collecting evidence from interviews • Inviting witnesses to interviews • Structuring interviews • Workshop D: Investigation of Dr Purple – interviewing witnesses (trainer-led role play).
16:35	Briefing on homework
16:45	*Close*
Homework	**Approx 1 hour to be undertaken in advance of Day 2** Prepare for Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)

DAY 2

08:45-09:00	*Registration and refreshments*
09:00	Review of day 1 – learning points
09:10*	**Workshop E: Investigation of Dr Purple – interviewing witnesses (delegate-led role play)** **Refreshments available at 11:00*
11:15	**Report writing:** • Drafting a witness statement • Following up with witnesses • Structure • Workshop F: Investigation of Dr Purple – report writing.
12:45-13:30	*Lunch*
13:30	**Workshop F: Investigation of Dr Purple – report writing (cont)**
14:00	**Supporting the practitioner**
14:05	**What happens next?** • Presenting the management case • Consideration of report • Outcomes • Remediation.
14:25	**Responding to legal challenges – the role of the case investigator**
14:40-14:55	*Break and refreshments*
14:55	**Workshop G: Investigation of Dr Purple - responding to legal challenge**
15:25	**Support for case investigators including top tips from experienced AMDs at Southern Health & Social Care Trust**
15:50	**Review of learning**
16:00	*Close*

Learning methods

There will be a number of opportunities for delegates to discuss and explore their own experiences and case studies in an appropriately confidential setting. Case studies will be used as learning tools for individual skills development and sharing of learning and experience.

NCAS' Statement of principles

During the workshop NCAS will present fictional learning material, which has been compiled through NCAS' work, to enable the sharing of your and NCAS' experiences of dealing with concerns about practitioner's performance. When discussing your own experience of cases, please make every effort to ensure that any information which identifies individuals or organisations is removed and fully anonymised. If you do hear information about a case which leads to, or gives the impression of, identification of the details of the case please treat

this information as **strictly confidential**. For more information about NCAS' Statement of principles please access our website on http://www.ncas.nhs.uk/events/confidentiality-principles/

Facilitator biographies

Dr Colin Fitzpatrick

Senior Adviser (Northern Ireland), National Clinical Assessment Service

Colin established the NCAS service in Northern Ireland in 2005 and became the Senior Adviser for NCAS (Northern Ireland) in 2008, with responsibility for developing the service and leading the NCAS team there. Colin has considerable experience of dealing with practitioner performance issues, having worked as a GP medical adviser in the Eastern Health and Social Services Board for 13 years. Since 2005, Colin has also managed a workforce of over 100 part-time and full-time GPs in the Down Lisburn Trust Out of Hours Services, and is now Clinical Director (Primary Care & Prison Healthcare) in the South Eastern Health and Social Care Trust. He is a GP partner in Comber, a former member of the Council of the Pharmaceutical Society of NI, and a member of the Executive of the Royal College of General Practitioners in Northern Ireland.

Grainne Lynn

Adviser, National Clinical Assessment Service

Grainne qualified from Queen's University Belfast in 1983. After working for two years in the Royal Victoria Hospital she moved to Derry as a dental officer with the community dental services. In 1990 she obtained Fellowship of the Faculty of Dentistry from the Royal College of Surgeons in Ireland. From 1992-96 she worked part-time in general dental practice and in community dentistry. In 1996 she was appointed as Clinical Director of Dental Services in Foyle Trust where she worked until 2004. Grainne was appointed to NCAS in 2005 and initially combined this with providing dental services to prisoners in Magilligan Prison in Northern Ireland. She also worked until 2007 with the Health Service Executive (HSE) in Donegal. In 2007 Grainne retired from the practice of clinical dentistry and currently works full-time with NCAS. In 2010 she completed an LLM in employment law.

Case investigator training

Secondary Care

Day 1

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Welcome and introductions

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Learning objectives

By the end of the workshop, you will be able to:

- Explore how concerns about a doctor's practice arise and identify the most common factors affecting performance
- Explain why the decision to investigate is made and suggest other options to resolve performance concerns
- Describe roles and responsibilities of those involved in investigations
- Plan for an investigation which meets national requirements
- Describe the principles of robust and meaningful Terms of Reference and know how to work within them

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Learning objectives (cont)

- Collect, review and weight evidence
- Conduct an investigative interview using a structured approach
- Recognise the key skills and attributes of a case investigator
- Recognise their own limits of competence and access sources of support and expertise
- Reference relevant national/local standards
- Write an investigation report with conclusions
- Describe the potential legal challenges to an investigation.

Programme overview

Day one

- Dealing with concerns about a doctor's practice
- Investigation roles and responsibilities
- Starting the investigation, including TOR, linking with the CM and bias and prejudice
- Gathering evidence including documentary evidence and interview evidence
- Homework

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Programme overview

Day two

- Investigative interviewing – interviewing witnesses (workshop)
- Report writing (including exercise)
- Supporting the doctor
- What happens next?
- Responding to legal challenges (including workshop)
- Support for case investigators

Dealing with concerns about a doctor's practice

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Dealing with concerns about a doctor's practice

- Definition of a concern
- How concerns arise

Investigation:

- What is it?
- Why do it?
- Other options
- Link with revalidation.

- *Maintaining High Professional Standards in the Modern NHS* (MHPS)
- *Performers List Regulations*

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Definition of a concern

"A concern about a doctor's practice can be said to have arisen where an incident causes, or has the potential to cause, harm to a patient, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice." (GMC, 2006)

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Definition of a concern

Concerns arise from any aspect of a doctor's performance or conduct which:

- Pose a threat or potential threat to patient safety
- Expose services to financial or other substantial risk
- Undermine the reputation or efficiency of services in some significant way
- Are outside acceptable practices, guidelines and standards.

How to conduct a local performance investigation, NCAS

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Discussion

- How are concerns raised in your organisation?

Fitness for purpose and fitness to practise

Fitness for purpose:

- Expected standards for specialty/grade
- Set by employer or commissioner.

Fitness to practise:

- Minimum standards for specialty/grade
- Set by GMC and informed by college/faculty.

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Triggers for a concern

- Colleague concerns
- Clinical incidents
- Complaints
- Data monitoring – mortality
- Quality outcomes
- Clinical audits
- Compliance with national guidance
- Criminal incidents
- Doctor's own concerns
- Feedback
- Whistleblowing

The majority of doctors provide a high standard of care.

All doctors will experience a variation in their level of practice and clinical competence during their career.

Responsible Officers (ROs) must have corporate governance systems in place to allow early detection of triggers so that concerns about a doctor can be addressed appropriately.

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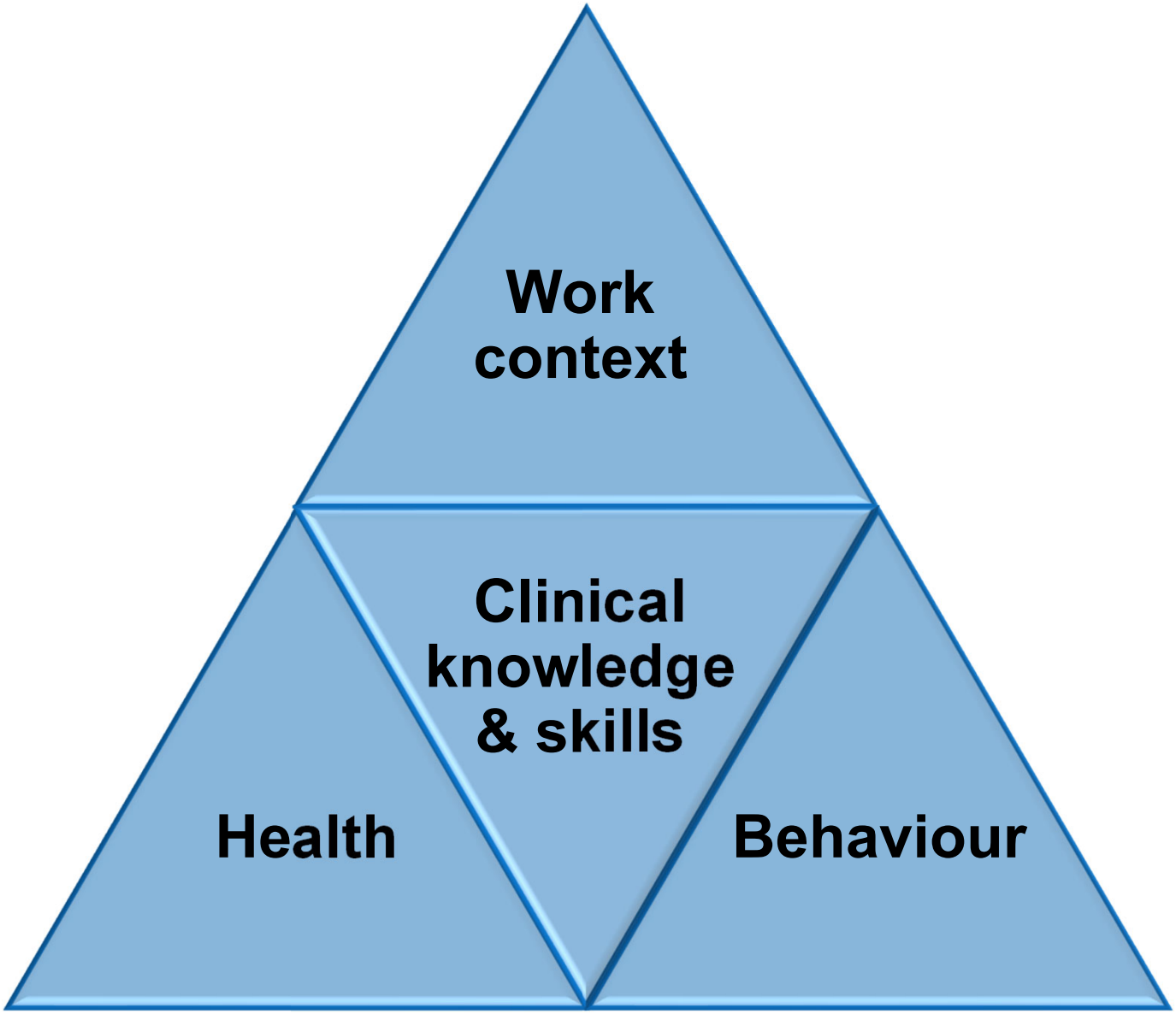
What concerns come forward - the performance triangle



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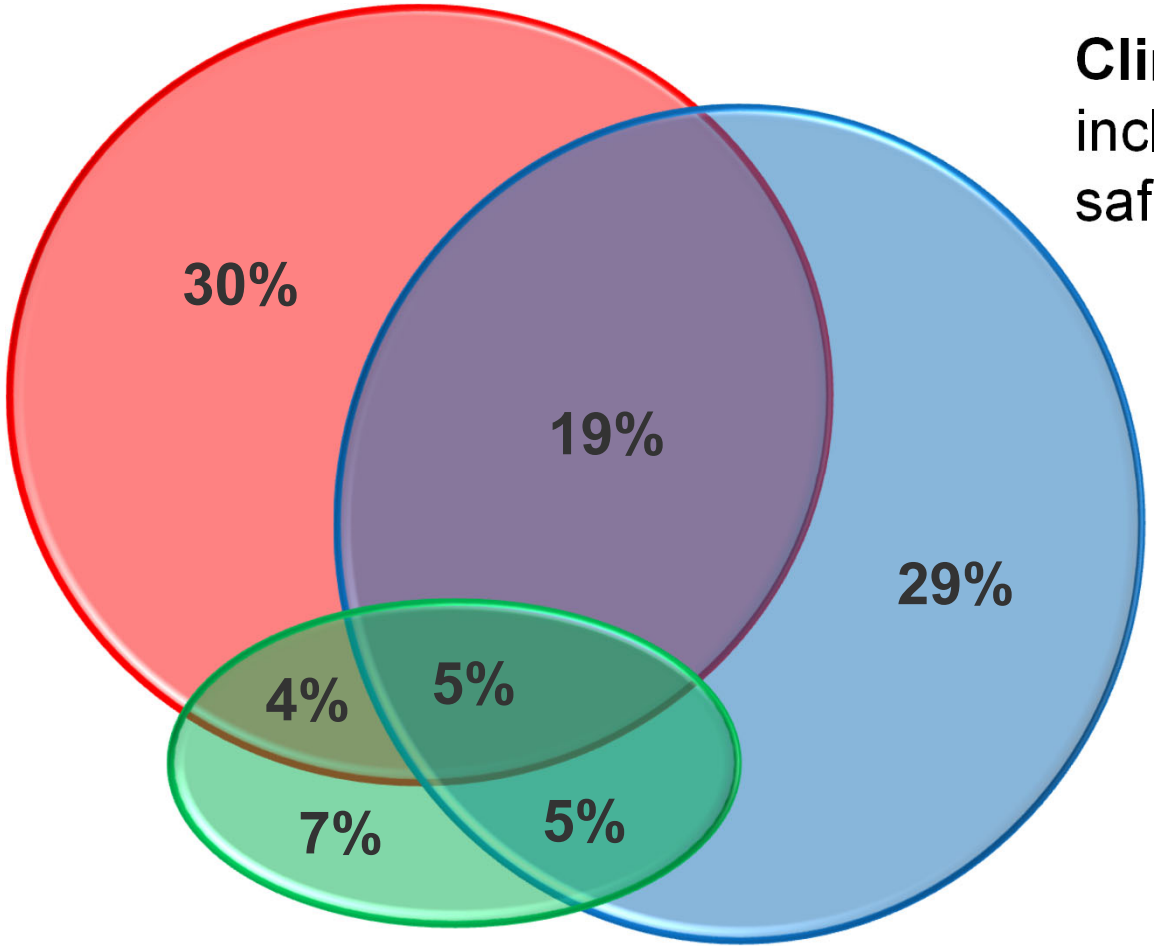
What concerns come forward - three main areas

Behaviour / misconduct – 58%



Clinical concerns including governance/ safety 58%

Health concerns 21%

Sample - 5634 cases referred to NCAS Dec 2007 – Sept 2013

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Procedures and good practice guides for managing concerns (in England)

- **Procedures for NHS Trusts**
  - *Maintaining High Professional Standards in the Modern NHS (*Department of Health, 2005)
- **Procedures for GP Performers Lists**
  - *The National Health Service (Performers Lists) Regulations No 335 (*Department of Health, 2013*)*
  - *NHS England Policy and Procedures 2013*
  - *Primary Medical Performers Lists – Delivering Quality in Primary Care,* (Department of Health, 2004)
- **Good practice guides relevant to all sectors**
  - *Remediation Report – Report of the Steering Group on Remediation* (Steering Group on Remediation, 2011)
  - *Tackling Concerns Locally* (Department of Health, 2009)
  - *Supporting Doctors to Provide Safer Healthcare – Responding to concerns about a doctor's practice* (RST 2013)
  - *Code of practice: Disciplinary and Grievance Procedures* (ACAS 2009)

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MHPS

- *Maintaining High Professional Standards in the Modern NHS* (MHPS) describes the procedures which Trusts have to follow for handling concerns about conduct, performance and health
- Detailed process is described with clear separation of roles and responsibilities
- Includes guidance on when to involve NCAS
- Local procedures must comply

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MHPS

Contents

- Part I: Action when a concern arises
- Part II: Restriction of practice and exclusion
- Part III: Conduct hearings and disciplinary matters
- Part IV: Procedures for dealing with issues of capability
- Part V: Handling concerns about a doctor's health

Performers List regulations

- Application
- Requirements with which a performer must comply
- Contains disciplinary process including grounds for:
  - Removal (including conditional inclusion)
  - Suspension from the Performers List:
    - Suitability
    - Efficiency.
- Appeals mechanisms

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Summary of principles common to all performance frameworks

- Patients must be protected
- Action should be based on proportionate and defensible concern about risk
- All action must be proportionate and defensible if challenged
- The process must be clearly defined and open to scrutiny
- The process should demonstrate equality and fairness
- All information must be safeguarded
- Support must be provided to all those involved

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Corporate leadership

- Commitment from the highest level of the organisation
- Policy describing the processes approved at board level
- Quality assurance, for example: process reviewed annually, data collected, case investigations (annual board report)
- Openness, transparency and fairness
- Full integration with clinical/corporate governance systems for early identification of concerns

What is investigation?

- Investigation: identifying facts (what happened and how?) around an event or set of circumstances
- *"It is important to define what I mean by the term 'investigation'… I mean the gathering of information and evidence relating to the circumstances giving rise to a complaint"* – Dame Janet Smith

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When investigation is likely to be appropriate

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

- Pose a threat or potential threat to patient safety
- Expose services to financial or other substantial risk
- Undermine the reputation or efficiency of services in some significant way
- Work outside acceptable practice guidelines and standards.

When an investigation may not be necessary

Where:

- It is reasonably certain that all relevant information is directly to hand
- Informal action is agreed
- Reported concerns do not have a substantial basis e.g:
  - Are refuted by other available evidence
  - Are frivolous, malicious or vexatious.
- The case needs to be referred to the Police or NHS Protect
- Confirmed or suspected ill-health which would make an investigation inappropriate
- Concerns are being investigated by another agency
- Sufficient evidence exists to take action or the practitioner agrees with the relevant facts and there is a local procedure that provides for resolution without formal investigation.

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Preliminary gathering of facts

- An initial review and assessment of facts to enable the CM to make a decision about whether there is further evidence to gather
- Would usually involve the practitioner
- Does not include Terms of Reference

Protecting and supporting those involved – protect patients from harm

Depending on the level of concern the CM/RO/DMG has to manage risk (including to patient safety) and decide:

- If the doctor should be excluded/suspended
- If the doctor should have practice restricted
- Whether the Regulator should be informed
- Whether others should be informed, for example, police
- Where the doctor becomes unavailable, for example, resigns - referral to the Regulator (consider Healthcare Professional Alert Notices (HPANs).

CM should contact NCAS as soon as possible when above considered.

CM must document decision process.

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Exclusion/restriction/suspension

- The purpose is to manage risk, including protecting patients and staff
- Can also be needed if presence of doctor would impede investigation and gathering of evidence
- It is ostensibly a neutral act, but its impact is unlikely to be
- Inform other organisations where doctor works (RO to RO)
- NCAS should be involved when exclusion considered
- When managing risk, consider alternatives for example restrictions to administrative duties, limited clinical duties
- If practitioner takes a period of sick leave this will supersede exclusion

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Workshop A

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Investigation roles and responsibilities

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Provision of skills
Case managers and case investigators

Case managers and case investigators should be:

- Identified
- Trained (RO regulations state ‘qualified’)
- Developed
- Supported
- Accountable.

- Note: Can be internal or externally commissioned or shared between organisations

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Case investigator

- Appointed by and accountable to the case manager
- Requires appropriate training and experience
- Must not have conflict of interest or appearance of bias
- Works to agreed timescales and agrees variances to this
- Works within the Terms of Reference and refers to case manager for amendments
- Keeps the doctor and the case manager informed of timescales and progress
- Plans the investigation: documents and interviews
- Records the process

Case investigator (cont)

- Collects and identifies relevant evidence
- Collates primary evidence
- Summarises the evidence
- Reports on the findings of fact
- Writes conclusions
- Is not involved in decision on outcome of case or what happens next
- May be required to give evidence at a panel hearing or employment tribunal
- May be required to represent witnesses at a panel hearing or employment tribunal

Case manager

- Nominated by decision makers in the organisation
- Ensures investigation is conducted efficiently
- Acts as co-ordinator between the doctor, case investigator and others interviewed. Should not be involved
- Ensures confidentiality, proper documentation of the process and ensures access to any documentation required by the case investigator
- MHPS normally requires this to be the Medical Director/RO for cases involving consultants or clinical directors, though it is often delegated
- Ensures the doctor has appropriate support
- Makes judgments on the basis of the report and other information
- No conflict of interest or appearance of bias
- Is not involved in investigation detail itself
- Determines next steps on receipt of report

Responsible officer

Among their duties, and in the context of responding to concerns about a doctor's practice, the responsible officer must:

- Identify concerns through corporate governance processes
- Initiate investigations and ensure they are carried out with appropriately qualified investigators separate from the decision-making process
- Initiate further monitoring
- Initiate measures to address concerns which may include re-skilling, retraining, rehabilitation services, mentoring or coaching
- If necessary exclude/suspend a doctor or place restrictions on their practice pending further investigation
- If necessary refer to the GMC and comply with the conditions applied by the regulator and provide appropriate information as required
- Address any systemic issues within the designated body which may have contributed to the concerns identified.

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Provision of skills
Decision Making Group - DMG

- If present, this is a group which helps RO and/or CM with decision making around concerns management including the need for and outcomes of investigations
- Who could be on this group? HR manager, deputy RO, director of education, appraisal and revalidation lead, lay member (non-executive director of the board), doctor representatives
- People with the right skills should be selected for the DMG
- Legal representation or access
- There should be Terms of Reference for the DMG
- DMG's connection with the relevant policies should be clear, for example, remediation, disciplinary policies

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Decision Making Group (DMG) - Decision makers

If present, remit could include:

- Agreeing or writing Terms of Reference
- Preliminary decision on category and level of concern
- Deciding on action required and who else to involve, for example, commissioning of an investigation
- Consideration of practice restriction/suspension/exclusion
- Appointing case manager and case investigator and providing timescales
- Deciding with the RO on further action at conclusion of the investigation.

Others who may be involved in investigation process

May include:

- Human resource director – advises on process and helps responsible officer and others make the decisions
- Occupational health consultant – gives case manager (not CI) reports on assessments of doctor
- Designated board member (most often non-executive director) - oversees the process, makes sure timelines are met and doctor is kept informed throughout
- Director of education – advises on educational remedial processes
- Dean if trainees are involved
- Appraisal and revalidation lead – advises on revalidation issues with RO
- Clinical experts or other subject matter experts.

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Other stakeholders

May include:

- Colleagues
- Police
- Counter Fraud Service/NHS Protect
- GMC (including Employer Liaison Adviser (ELA))
- Medical defence organisations – may be representing the doctor in investigation and panel hearings
- Professional associations, for example, BMA – may be representing the doctor in investigation and panel hearings
- NCAS – may be contacted by DB and/or doctor for advice
- Patients/families/carers – should be kept informed of processes whilst preserving confidentiality of the doctor and others involved
- Public – there may be a need to speak to the press BUT this needs to be controlled by the organisation with limited responses stating process and protecting those involved.

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Protecting and supporting those involved

Organisations should, as appropriate:

- Protect patients from harm
- Protect people raising concerns
- Keep patients informed
- Support the doctor
- Protect the organisation.

If the case investigator discovers any risk to patient safety at any stage they should discuss with the case manager.

Supporting the doctor

- Doctor entitled to confidentiality
- Case manager meets with doctor to inform him or her of investigation, the Terms of Reference and timescales
- At any stage the doctor has the right to be accompanied (*Employment Relations Act 1999*). This may be by friend, partner, BMA rep, defence organisation or lawyer
- Processes need to be explained to the doctor
- The need to avoid influencing witnesses and investigation

- Personal support for doctor should be offered, for example via occupational health and/or GP, MDO, BMA, Deanery etc

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Protecting those involved – people raising concerns

- Whistleblowers should be protected under Public Interest Disclosure Act 1998
- Difficult to protect identity of witness in a small team
- Remind doctor and others to avoid action which may be seen to influence investigation
- Witnesses may want to be anonymous (may be necessary, case investigator may have to appear at panel hearing for them and must protect identity of witness in report)
- Offer other support if stressed, for example mentor, occupational health

Protecting and supporting those involved – keep patients informed

- Patients/families who have made the complaint should receive information on organisation's complaint process
- A 'look back' exercise may require an announcement and the patient may be told there is an investigation
- The proposed information release should be discussed with doctor first and he or she should be protected

Protecting and supporting those involved – dealing with the media

- Media enquiries dealt with by organisational processes and confidentiality of patients and doctor protected
- Any media release should be discussed with doctor first and he or she should be able to contact defence society for advice

Protecting and supporting those involved – protect the organisation

- Those involved in making the decision to investigate, or in the investigation itself should not be involved in decision making at subsequent disciplinary hearings or appeals
- Case investigators are not involved in decisions to take formal action
- If doctor raises a grievance or complains of bullying and harassment this must be assessed using local policies and overseen by a manager not in the current investigation

Starting the investigation

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Terms of Reference

Terms of Reference are agreed by the case manager, issued to the case investigator, and should define the:

- Issues to be investigated
- Boundaries of the investigation
- Period under investigation
- Timescale for completion of investigation and submission of a report
- Issues which are not disputed

- The TOR document will reference information which has been provided by the case manager

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Terms of Reference – top tips

- ToR should prevent unfocused or ‘general’ investigation
- ToR should be seen and reviewed by the doctor
- ToR may need to change during an investigation to broaden or narrow the scope

Planning the investigation

- DMG (if present) appoints CM and CI
- Terms of Reference agreed with CM
- CM may meet doctor (accompanied) to explain process, ToR and who is CI. CM confirms this in writing
- CM and CI meet to confirm process and timescales
- CI supported by CM to have time to complete investigation in four weeks and report completed five days after that (*MHPS)*
- CI plans investigation, based on information about concern already known, for example, who to interview and other evidence needed
- It may be helpful to have help

Liaising with the CM

It is important to agree the following ground rules before undertaking an investigation (remembering to confirm them in writing):

- Terms of Reference
- The time frame of the investigation
- Dates of attendance at the unit, where you will be working and what will be told to other people working in the unit
- How patient consent is to be treated
- Access to the records (such as passwords for computerised records)
- What to do if there are issues of immediate concern / patient safety issues
- Payment (how much/how long (reviewing evidence and producing the report)/by when/whether a contract is required)
- Indemnity
- That there is no conflict of interest
- Who keeps copies of the report and for how long you will keep a copy.

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Principles of investigation

Investigations should be:

- Fair
- Relevant
- Impartial
- Timely.

Maintain your own personal integrity and professionalism.

Fairness

- Doctor is entitled to know what is said against them and to comment before a decision is made
- Doctor should be able to expect the decision maker is impartial
- All involved should have training
- All policies relating to this process - for example, organisational disciplinary and remediation policies - should receive an equality impact assessment
- Equality and diversity issues cover:
  - Gender
  - Race
  - Disability
  - Age
  - Religion/belief
  - Sexual orientation and gender reassignment
  - Marriage/civil partnerships.

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Fairness

Be aware that looking at referrals and suspensions NCAS found associations with:

- Age and gender:
  - Male > female
  - Older > younger.
- GP v hospital/community doctors:
  - GPs are about twice as likely to be suspended from work as hospital/community doctors
  - GP suspension episodes last about twice as long as H&C (44 weeks compared with 19 weeks).
- Ethnicity and place of qualification associations:
  - Place of first qualification is a risk factor for progression through FTP irrespective of ethnicity
  - Place of qualification both inside and outside EEA
  - Among those qualified in the UK ethnicity was not a source of additional risk.

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Perceptions/bias case studies

Which of these case studies would you find most difficult to investigate?

A. 65 year old viewing pornography at work.
B. 35 year old reported with sexist attitudes.
C. 30 year old who persistently turns up late, uses his mobile phone at work.
D. Senior consultant who is clinically brilliant but refuses to wash his hands.
E. GP who refuses to refer for termination of pregnancy due to her own religious beliefs.
F. Any more?

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What is conflict of interest?

Conflict of interest

A situation in which someone in a position of trust has competing professional or personal duties, loyalties, obligations or interests that would either make it difficult to fulfil their duties fairly, or would create an appearance of impropriety or a loss of impartiality that could undermine public confidence.

Bias or the appearance of bias

A predisposition, prejudice or preconceived opinion that prevents impartial or objective evaluation or the appearance of such based on reasonable grounds.

Composite definition from several sources

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Conflict of interest or appearance of bias

- Where there is or has been a **personal** relationship (marriage, partnership) between a responsible officer and a doctor or where the two are related in any other way
- Where there is a **financial** or business relationship between a responsible officer and a doctor
- Instances where a **third party** is involved for example an affair or marriage breakdown
- Where there is a known and **long-standing personal animosity (or friendship)** between a responsible officer and a doctor

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Workshop B

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Gathering evidence

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Sources of potential evidence

- Documentary evidence
- Evidence collected from witnesses
- Other forms of evidence

- Negative
- Positive
- Benchmarking

Index of evidence

- Date evidence obtained (documentary or from interviews)
- Source (department obtained from; Name of the person providing evidence)
- Description of evidence
- Notes (including weighting comments)
- ToR reference
- Further information needed

If removed from investigation:

- Date removed
- Reason for removal.

Documentary evidence

- Need to ensure reliability – the more sources and items of evidence the greater the reliability
- Ensure you include sources of information with the potential to support or refute the allegations
- Ensure all aspects of the Terms of Reference are covered
- Check your evidence by asking these questions at the start and end of the review:
  - Does the evidence cover all the Terms of Reference?
  - Does the evidence address the matters of concern?
  - Does the selection of the evidence ensure a lack of bias?
  - Does the evidence exclude items which are not relevant?

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

Documentary evidence

- Be familiar with how the documentary evidence is stored, its format and how it should be accessed (if not provided directly by the CM)
- Agree somewhere private for you to work if you need to be within the organisation
- Know how to identify the doctor's contribution, for example, within a MDT or clinical audit data
- Be clear about how to respond if immediate action is required (part of the agreement process with the CM)
- Ensure documentary evidence reviewed as part of the investigation is passed back to the CM and the CI does not retain – agree how this will happen at the same time as the ToR

Patient consent

- How you will handle gaining patient consent is the decision of the CM and should be agreed at the same time as the ToR
- Ensure that all patient information in the report is treated with strict confidence

Evidence/comments from the doctor

- Doctor should know what documentary evidence is being reviewed (ToR)
- Doctor should be encouraged to submit **relevant** additional evidence and comments in line with the ToR

National and peer standards and guidance

- Consider the good practice guidance relevant to the doctor you are reviewing:
  - National (NICE, Royal College, Faculty etc)
  - Local (need to be gained from CM)
  - BNF
  - *Good Medical Practice* and relevant specialty guidance, for example, *Good Medical Practice for General Practitioners* or *Good Psychiatric Practice.*
- Ensure you have access to the good practice guidance relevant to the doctor during the investigation

The robustness of the evidence – factors to consider

- Format of evidence
- Timeliness of evidence (time collected and time since incident)
- Patterns of evidence
- Directness of evidence
- Credibility of evidence
- Consistency of evidence
- Technical competency of evidence giver
- Likelihood of evidence to be challenged successfully.

- Standard of proof is the civil standard – the balance of probabilities (more probable than not)

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Workshop C

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Gathering evidence from interviews

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Collecting evidence from interviews

- To obtain a detailed and accurate account in a way which is fair and is acceptable for the investigation report

Inviting witnesses to interviews

- Consider timing of interview (with demands of the investigation)
- Provide sufficient notice to attend
- Always suggest interviewee can bring a supporter
- Give the interviewee notice of the areas you want to talk about (linked to TOR)
- State the purpose of the interview
- Who will be present
- Location of interview
- How long likely to take
- General structure of the interview (including confidentiality) and any ground rules
- The practitioner is treated the same as all witnesses in the investigation i.e. afforded the same rights

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Inviting witnesses to interviews

- Doctor should be written to explaining:
  - Investigation process, what is being investigated, confidentiality
  - Invitation to be interviewed with reasonable notice to meet at a mutually convenient time and venue
  - Their right to be accompanied
  - Copy of Terms of Reference, list of witnesses and disclosure file.

Structured approaches to interviews

- Five main phases:
  - Plan
  - Establishing rapport
  - Initiating and supporting a free narrative account
  - Questioning
  - Closure.

- Start with a free narrative phase
- Gradually become more and more specific in the nature of the questioning to elicit further detail

Planning

- Provide guidance to the interviewee about what might be expected
- Plan key detailed questions which cover all areas of the ToR
- Ensure the venue is suitable
- Plan arrangements for taking notes and how interview transcripts and statements are dealt with *(more later….)*

Establishing rapport

- Welcome interviewee
- Confirm who is present
- Summarise the reason for the interview in a neutral tone
- Consider need to ask neutral questions not related to the event
- Explain what is expected of the interviewee
- Provide outline of interview (include confidentiality)
- Explain if the interviewer asks a question they do not understand or that they do not know the answer to, they should say so
- Explain if the interviewer misunderstands what they have said or incorrectly summarises what has been said, interviewee should point this out
- Encourage sharing of detail during the interview

Free narrative account

- Ask for a free narrative account of the incident or event(s)
- Try not to interrupt the interviewee too early
- Encourage interviewee to provide an account in their own words by non-specific prompts:
  - Did anything else happen?
  - Is there more you can tell me?
  - Can you put it another way to help me understand it better?
  - How would you describe...
  - Tell...
  - Explain...

Free narrative account

- Display active listening, letting the interviewee know what they have communicated has been received
- Reflect back to the interviewee what they have just said, for example "*I didn't like it when he said that*" (interviewee) then "*You didn't like it*" (interviewer)

Questioning

- Ask appropriate questions which assist further recall or explain reasoning/rationale
- Explain you will now be asking some questions, based on what has already been communicated, in order to expand upon and clarify what the interviewee has said
- Divide areas of questioning into manageable topics:
  - Introduce an open-ended invitation to focus on and recall the subject matter of the topic-area in detail
  - Probe systematically using open-ended ('tell me', 'describe', 'explain' – enable interviewee to control the flow of information) and specific-closed questions ('why', 'what', 'where', 'when', 'who').
- Avoid topic hopping

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Questioning

- Move on to deal with any case-specific information identified as important when planning the interview:
  - Organise case-specific information into topic-areas.
- Do not introduce case-specific questions until general questioning has been undertaken to avoid confusing the recollection of the incident

Closing the interview

- Summarise what the interviewee has said, using the words and phrases used by the witness as far as possible
- Tell interviewee to correct you if you have missed anything out or if information is incorrect and to add information if they remember more details
- Thank interviewee for attending, their time and effort
- Remain neutral – do not congratulate or convey disappointment in the interviewee
- Explain next steps but do not make false promises
- Ask interviewee if they have any questions
- Provide contact details if interviewee wishes to contact you with further information along with sources of support

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Top tips for interview

- Keep the questions short, simple, neutral, plain language, only one question at a time
- Avoid jargon and clinical language wherever possible
- Try to keep the questions open – so the answer isn't just ‘yes’ or ‘no’
- Signpost the particular patient and/or incident you wish to question
- Keep the language neutral
- Ensure your questions cover all issues in the ToR
- Go at the pace of the interviewee
- Vary intensity for vulnerable interviewees
- Convey respect, sympathy and professionalism

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Top tips for interview – conducting the interview

- If you need to probe, ensure you remain within the scope of the ToR
- If the interviewee doesn't understand, then repeat or rephrase the question as closely as you can to the original wording
- Don't give feedback and be aware of non-verbal signals
- Tell interviewee at start of interview you are impartial and won't be giving them a reaction

- Record the responses in full
- After the interview, add to index of evidence and link to ToR

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Workshop D

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Homework (approx 1 hour)

- Prepare for the interview skills session:
  - As an interviewee (Dr Maroon, Staff Nurse Red OR Dr Purple)
  - As the case investigator.

IN GROUPS OF 3

	DELEGATE 1	DELEGATE 2	DELEGATE 3
Scenario 1	Dr Maroon	Investigator	Observer
Scenario 2	Observer	Staff Nurse Red	Investigator
Scenario 3	Investigator	Observer	Dr Purple

- Each scenario lasts 30mins: 20min interview plus 10mins reflection/feedback

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Case investigator training

Secondary Care

DAY 2

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Review of learning points from Day 1

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Remember

Purpose of the investigation is to identify relevant evidence in an objective and impartial way and produce a report

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Workshop E – Role plays

	DELEGATE 1	DELEGATE 2	DELEGATE 3
Scenario 1	Dr Maroon	Investigator	Observer
Scenario 2	Observer	Staff Nurse Red	Investigator
Scenario 3	Investigator	Observer	Dr Purple

- Observer forms (pink paper): ***Use this form to record observations about the case investigator role:***
  - The CI has prepared effectively for the interview
  - The CI establishes rapport
  - The CI initiates and supports a free narrative account
  - The CI questions effectively
  - The CI closes the interview effectively.
- Self-reflection forms (blue paper): ***Use this form to reflect on your own performance as a case investigator from the role plays***

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Workshop E

Learning points from interviewing role plays

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Documentation and report writing

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Documentation and witness statements

- Interviews should be recorded in writing and a note taker may be provided
- Interviews may be recorded (use with care) but the witnesses must be told what will happen to the recorded material. Usually used to transcribe the interview

Documentation and witness statements

- Witness statements are prepared after the interview:
  - Format:
    - Numbered paragraphs
    - Statement of truth, for example: "*This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a disciplinary hearing. I understand that I may be required to attend any hearing as a witness.*"
    - Signed and dated
  - Introductory paragraph:
    - Name and job role
    - Why statement being given (reference local policy)
  - Use "I" and the interviewee's exact words and phrases wherever possible
  - Cross reference to documents and attach them as exhibits
  - Witness statements contain evidence relevant to ToR – may be narrower than transcript of evidence
  - Be consistent
- Transcript of interview is separate from statements
- Supplementary statements may be necessary e.g. if TOR change

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Weighting evidence

- Weighting evidence means making judgements about it. A case investigator needs this skill which must be applied consistently and impartially in order to come to findings
- Weighting the evidence means understanding the balance of probabilities and taking as true anything which appears more probable than improbable
- The more serious the concerns about the doctor, the greater the need for the investigators to satisfy themselves that the evidence supports their findings of fact

Considering the evidence

- Avoid starting the investigation with preconceived ideas about the doctor
- State both satisfactory and unsatisfactory practice
- Corroborate individual examples of evidence with other individual examples
- Check your analysis with the Terms of Reference to ensure you are answering the questions the CM wished to address

Report writing - discussion

- Have you written a report?
- What were the challenges?

Report writing

- The report should be self contained
- The report should reference witnesses
- All evidence should be appended to report wherever possible
- The report should not allow individual patients or members of the public to be identified by name

- The report and all other evidence and records should be kept secure and handled in accordance local and national guidance, *Data Protection Act 1998 and the NHS Code of Practice on Confidentiality (Department of Health* 2003)
- There are no nationally set rules for retention periods but this needs to be determined by organisational policies (agree at same time as ToR)

Report writing

- Cover page
- Contents
- Introduction
- Background
- The investigation
- Methods
- Findings of fact
- Conclusion
- Appendices
- Name and biography of case investigator(s) (*date and signed*)

Report writing - structure

Introduction

- Give a brief introduction to the investigation, its relationship with any investigations by other bodies and the procedures and regulations governing the present investigation
- You should include references to organisational polices being followed

Background

- Include relevant career information about doctor, work and role within the organisation
- Reasons for the investigation in more detail

Report writing - structure

The investigation

- Specific allegations for investigation
- Describe the team carrying out the investigation (with names, job titles and qualifications)
- The terms of reference as set initially plus any subsequent amendments

Methods

- This should include for example:
  - Review of documentary evidence, including patient records
  - Interviews with specified patients and/or colleagues.
- Details of expert witnesses (including qualifications and biography)
- State what has happened in the investigation process and explain any delays

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Report writing - structure

Findings of fact

- Set out in detail all relevant evidence
- Under each ToR set out the chronology of the incident (where possible) and link to exact items of fact from the supporting evidence
- Where the fact-finding includes the opinion of case investigators or other experts on a standard of care, the required standards of care should be quoted (and included as an Appendix)
- Draw attention to any conflicts of evidence and whether it was necessary to resolve the conflicts in order to complete the investigation. Rationale should be given for preferring one version of events to another

Report writing - structure

Conclusions

- Summarise evidence in respect of each of the points listed in the Terms of Reference
- Cross-referenced to the findings of fact

Appendices include relevant evidence

All the relevant evidence should form the appendices:

- Terms of reference
- Witness statements
- Standards used
- Physical evidence may include:
  - *Medical records*
  - *Letters of complaint*
  - *Clinical incidents*
  - *Computer records e.g. e-mail, social networks*
  - *CCTV and telecommunications data.*

Appendices: Examples of standards

- Refer to appropriate national standards whenever possible e.g.
  - *College guidance*
  - *NICE guidance*
  - *GMC guidance*
  - *NHS England*
  - *Department of Health guidance.*
- National policy and procedures
- Local policies and clinical pathways in organisations, for example, if the incident is about poor note keeping look for local policy as well as national

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Errors and types of errors

- Check your own work thoroughly, considering:
  - Has the evidence been transcribed correctly?
  - Is the evidence set out clearly in appropriate language?
  - Is the evidence coherent?
  - Is it clear why the allegations have been accepted or dismissed?
  - Is the report internally consistent?
  - Are all the facts described and accurate?
  - Are any assumptions or inferences substantiated?
  - Is the report comprehensive covering all relevant evidence?

Report writing – top tips

- Be objective and give rationale for any decisions
- Keep the tone of the report neutral
- Report areas of both satisfactory and poor practice/conduct
- Do not introduce personal bias
- Be succinct but comprehensive
- Write in Plain English and avoid jargon
- Needs to be evidence-based
- Needs to be internally coherent.
- Needs to be defensible:
  - Against potential challenge from the doctor
  - Against potential challenge from the CM

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Workshop F

Read additional information (witness statements and site visit)

Draft findings of fact and conclusion sections for ToR1

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Supporting the doctor

- The CM is responsible for ensuring the doctor is supported throughout the investigation (including through BMA and Defence Organisations, OH, Counselling etc)

- CIs should be aware of support which is available for the doctor and:
  - Remain unbiased and objective
  - Ensure principles of investigation are maintained
  - Follow principle that doctor should know everything that is said about them
  - Follow principle that doctor should know the evidence upon which the investigation conclusions are based.

What happens next?

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Consideration of report

- Circulation is limited to the case manager and, where present, members of the DMG
- Doctor does not receive drafts of the report in case they interfere with the process
- Doctor should see final draft of the report and be invited to correct any errors of fact (NB Check local policy)
- Consider confidentiality of sharing
- The CM with the DMG makes the decision for further action
- Once the decision is made the case manager should meet the doctor to explain the outcome

Discussing the case with the CM

Provide an overview of the investigation:

- ToR
- Investigation process, including methods, sources of evidence
- Findings of fact against each of the ToR
- Any outstanding areas of doubt.

Outcomes

CM will decide:

- If no further action is needed
- If there is a case of misconduct that should go to panel
- If there are capability concerns (NCAS to be involved and/or panel)
- Restrictions in practice should be in place or if in place should be reviewed
- If there are serious concerns that should be reported to Regulator
- If there are health concerns
- If the matter should be progressed informally
- Organisational matters that need to be addressed, for example, policies.

NCAS can be consulted for advice at any stage.

Consider organisational learning.

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Responding to legal challenges – the role of the case investigator

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Process of disciplinary panel hearing

- Disciplinary panels follow process (MHPS), members are specified and must not have been involved in investigation
- Case manager usually presents the case of the employer
- Doctor or representative can present their case
- Case investigator may be called as a witness and will be if a witness wants to remain anonymous
- Two stage process:
  - Findings of fact
  - Sanction
- Possible outcomes:
  - No action
  - Written warning (usually with conditions)
  - Final written warning (usually with conditions)
  - Termination of contract.

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Process of appeal (MHPS)

- Doctor can appeal decision within 25 days and must state the grounds on which they are appealing
- Appeal panel consists of members not involved in disciplinary panel
- Hearing takes place within 25 days and decision in five days
- Panel decides if procedures have been followed in arriving at decision and:
  - There was a fair and thorough investigation
  - Sufficient evidence was presented to make decision
  - The decision was fair and reasonable, based on evidence.

Process of appeal (MHPS)

- Process is similar to disciplinary panel with case manager presenting employer's case
- The appeals panel can call witnesses of its own volition
- It can hear new evidence submitted by the doctor
- It should not rehear the entire case
- The appeal panel can decide:
  - The disciplinary panel decision was correct
  - To vary the disciplinary panel decision
  - Order a rehearing of the case (if processes were not followed correctly).
- The decision of the appeals panel is final

Employment Tribunals

- A doctor who is dismissed can take the case to an employment tribunal where the reasonableness of the employer's actions will be tested
- Employment tribunals examine organisational processes in coming to their decision
- The case investigator may be called to give evidence on process followed
- The ACAS code of conduct is taken into account and if the tribunal feels the employer has not taken the code into account they can adjust the award by 25%

NHS
National Clinical Assessment Service

ACAS code of conduct

When concerns are dealt with formally:

- Employers and employees should raise and deal with issues promptly and should not unreasonably delay meetings, decisions or confirmation of those decisions
- Employers and employees should act consistently
- Employers should carry out any necessary investigations, to establish the facts of the case
- Employers should inform employees of the basis of the problem and give them an opportunity to put their case in response before any decisions are made
- Employers should allow employees to be accompanied at any formal disciplinary or grievance meeting
- Employers should allow an employee to appeal against any formal decision made.

Workshop G

NHS
National Clinical Assessment Service

Why do investigations go wrong?

- Inconsistency, variation in quality, lack of transparency
- Variability of capacity/ability
- Delegation to staff who are too junior
- NCAS under-used, delays in seeking advice
- Wide differences in timescales
- Not always sufficiently objective, conclusions not always sound
- PCOs refer to regulator too readily instead of handling locally
- Complainants not kept in touch with what is going on
- Employers refer to regulator if contract of employment ends when in mid-investigation
- When registrant is line managed by a non-registrant the professional significance of concerns can be misunderstood

NHS
National Clinical Assessment Service

Expertise/support to the investigative process

- Remember your role is as CI – not as a doctor or a specialist
- Where clinical judgement is required, must involve a clinical adviser
- Clinical advice may be needed for area of specialty, for example internal senior clinician or Royal Colleges may be able to help
- Advice may be needed if you do not have the knowledge in certain areas, for example, computer skills to retrieve data
- When you believe the case needs escalation, get advice from the CM (who could seek advice from NCAS or GMC ELA)
- Seek legal advice, for example, if unsure how to treat a piece of evidence

What support is available for investigators?

- Peer support and networking:
  Organisations should consider how case investigators can get support from each other by having meetings of trained investigators, (case investigator support group, CISG, mentor).
- Quality assurance:
  Needs to be considered. Feedback from RO (or senior manager) and case manager after an investigation, anonymous feedback from witnesses.
- Maintaining and developing skills:
  Case investigators should keep up to date by incorporating feedback/reflections/courses in their appraisal and PDP.
- NCAS:
  NCAS can advise CI at any stage.

NHS
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Learning/feedback

National Clinical Assessment Service

Please respond to email sent this afternoon

- Workshop evaluation

  Please provide your feedback on the content of this workshop online at:

  http://www.ncas.nhs.uk/events/workshops/case-investigator-training-workshop/evaluation/

- NCAS and NHS England useful reading, templates and examples for case investigators and case managers:

  http://www.england.nhs.uk/revalidation/ro/resp-con/cit/reading/

NHS
National Clinical Assessment Service

Contact NCAS

England (Scotland and Wales)

- Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI
- Address: NCAS, NHS Litigation Authority 2nd Floor, 151 Buckingham Palace Road London SW1W 9SZ

Northern Ireland

- Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI
- Address: NCAS Northern Ireland Office, HSC Leadership Centre, The Beeches, 12 Hampton Manor Drive, Belfast, Co Antrim, BT7 3EN

NCAS Adviser Team: http://www.ncas.nhs.uk/about-ncas/ncas-within-nhsla/our-advisers/

NHS
National Clinical Assessment Service

Chloe Williams

From: Kiu Nghiem [redacted] >
Sent: 28 February 2017 12:04
To: Montgomery. Ruth
Cc: Gibson, Simon; Nneka Opute
Subject: NCAS Case Investigator training for Southern Health and Social Care Trust - 07-08 March 2017 - FINAL DETAILS
Attachments: Programme CI SHCT170307-08 Delegate v5 FINAL.pdf; Day 2 CI SECONDARY 161123.ppsx; Day 1 CI SECONDARY 161123.ppsx

Dear Ruth

I am pleased to confirm that we have now finalised all details for the NCAS Case Investigator training workshop we are delivering for Southern Health and Social Care Trust next week on the 07-08 March in Portadown.

Here is summary and final information to support the event:

Programme
A copy of the final programme is attached. Please note the timings for breaks/refreshments/lunch and ensure arrangements are made accordingly (please note asterisks against timings that indicate refreshments will be available during that session, rather than a scheduled break).

Before the workshop

- Boxes of training materials will be sent by courier to you this week. Please ensure you arrange for these boxes to be on site at the venue, at least 1 hour prior to the start of the workshop, on the day.
- Please check the presentation files work on the site system and get in touch with me ASAP if you encounter any problems.
- Delegate folders may be laid on tables or distributed to delegates at registration. Please pass the remaining materials to the facilitators.
- There shouldn't be anything left at the end of the workshop that will need to be couriered back to us. You may keep or dispose of any spare delegate folders or materials.

On the day

- Please ensure the boxes of materials sent are available in the room for the facilitators
- The facilitators will arrive for the workshop 45-60 minutes prior to the start. Please could someone brief them on housekeeping items such as where the toilets are, fire alarm and evacuation procedures, catering and lunch arrangements, what to do if they need help
- Load the presentation on the IT equipment and ensure it works and brief the facilitators on use of the equipment
- If you or someone will be on site to help with delegate registration, please use the registration form enclosed in the box of materials, ensure attendees are ticked or signed-in on each day of the workshops and distribute delegate training folders to delegates. After the workshop, please return a scanned copy or post the registration form to me (address in email signature)
- On the afternoon of Day 2 of the workshop, please send out the below correspondence to all attendees, the facilitators will have told them to expect it:

I do hope that you enjoyed the NCAS Case investigator training workshop and found it useful and beneficial. We would be grateful for your feedback on the content of the training and ask for you to complete the evaluation form online (it must be done in one sitting) and should take no longer than 4 - 5 minutes. You can access it here: http://www.ncas.nhs.uk/events/workshops/case-investigator-training-workshop/ci-evaluation/ Please complete your feedback by ***Friday 17th March.***

If you would like more information as a Case Investigator, you may find the materials and further reading at the following website useful (also includes sample investigation report for Dr Purple):
http://www.england.nhs.uk/revalidation/ro/resp-con/cit/reading

After the workshop

- I will be in touch to see how it went and if you have any initial thoughts on how it was received
- There shouldn't be anything left that will need to be couriered back to us, you may keep or dispose of any spare delegate folders or materials
- We will send you a template certificate a couple of weeks after the workshop to populate and circulate to attendees (note the workshop does not have CPD applied for but does count for 12 hours towards attendees CPD)
- I will produce an evaluation summary and circulate to you within 8 weeks after the workshop, once we have received at least 50% evaluation return rate

I wish you a successful event and of course if there are any other enquires please do get in touch.

With kind regards
Kiu

Miss Kiu Nghiem | Programme Executive (External Education) | Membership and Stakeholder Engagement Division
NHS Litigation Authority

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

Please note I work part-time on Tuesdays, Wednesdays and Thursdays

Address: NHS Litigation Authority, 151 Buckingham Palace Road, London SW1W 9SZ
Website: www.nhsla.com

No.	Delegate, Title, First and Last Name	Job Title	Organisation
1	Dr Richard Wright	Medical Director	SHSCT
2	Simon Gibson	Assistant Director	SHSCT
3	Lynne Hainey	Senior HR Advisor	SHSCT
4	Sarah Moore	Senior HR Advisor	SHSCT
5	Laura Crilly	Senior HR Advisor	SHSCT
6	Siobhan Hynds	Head of Employee Relations	SHSCT
7	Zoe Parks	Head of Medical Staffing	SHSCT
8	Malcolm Clegg	Medical Staffing Manager	SHSCT
9	Helen Walker	Assistant Director of Human Resources – Acute Services	SHSCT
10	Dr Hilda Nicholl	Consultant – Emergency Services	SHSCT
11	Dr Gareth Hampton	Consultant – Emergency Services	SHSCT
12	Dr Shahid Tariq	Consultant - Anaesthetics	SHSCT
13	Dr Andrew Ferguson	Consultant - Anaesthetics	SHSCT
14	Dr Damian Scullion	Consultant - Anaesthetics	SHSCT
15	Dr Colin Winter	Consultant - Anaesthetics	SHSCT
16	Dr Martina Hogan	Consultant - Paediatrics	SHSCT
17	Dr Rory Convery	Consultant - Respiratory	SHSCT
18	Dr Beverley Adams	Consultant – Obs & Gynae	SHSCT
19	Dr Ahmed Khan	Consultant - Community Paediatrics	SHSCT
20	Dr Joan McGuinness	Consultant – Mental Health	SHSCT
21	Dr Patrick McMahon	Consultant – Mental Health	SHSCT
22	Dr Neta Chada	Consultant – Mental Health	SHSCT
23	Dr Patricia McCaffrey	Consultant – Geriatric Medicine	SHSCT
24			

Sign in Sheet

NAME	Day 1	Day 2
Dr Richard Wright	Personal Information redacted by the USI	
Simon Gibson		
Lynne Hainey		
Sarah Moore		
Laura Crilly		
Siobhan Hynds		
Zoe Parks		
Malcolm Clegg		
Helen Walker		
Dr Hilda Nicholl		
Dr Gareth Hampton		
Dr Shahid Tariq		
Dr Andrew Ferguson		
Dr Damien Scullion		
Dr Colin Winter		
Dr Martina Hogan		
Dr Rory Convery		
Dr Beverley Adams		
Dr Ahmed Khan		
Dr Joan McGuinness		
Dr Patrick McMahon		
Dr Neta Chada		
Dr Patricia McCaffrey		
Norma Thompson		

Resolution

Case investigator training workshop

Workshop A: Exploring the issues
England / Secondary Care
DELEGATE VERSION

Dr Pink is a 38 year old consultant who has worked in the Obstetrics and Gynaecology department of a large hospital for five years.

The O&G department has good trainee satisfaction scores and is well regarded as a sociable and inclusive team. A patient has recently complained that they looked at Dr Pink's Facebook page where he had shared photographs from a team night out; this included one photograph of his naked partner (a nurse in the O&G team) and the caption "this was 3 hours ago – and she's just made it into work?!". The privacy settings have subsequently been changed and this is no longer public. The patient is nervous about providing formal evidence and at this stage only wants to make the hospital aware of the situation.

There are rumours about a department WhatsApp chat where sexual positions are shared along with swaps of clinical rotas. An explicit image was found by the temporary Receptionist in the deleted area of the communal computer.

Gossip and speculation about Dr Pink's personal life is spreading quickly within the hospital.

Questions to consider

- How might you deal with these concerns?

Resolution

Case investigator training workshop

Workshop B.1: Critiquing Terms of Reference (Dr Violet)
England / Secondary Care
DELEGATE VERSION

Dr Violet is a 46 year-old consultant physician, who for the last four years has been teaching medical students in the hospital. She is a long-standing member of the Trust Local Negotiating Committee (LNC) and is well known within the medical community and local media for her strong views on the NHS.

As part of her teaching, Dr Violet expects the students to present cases to her each morning. Dr Violet regularly becomes irritated if she feels that the cases have not been presented exactly to her standards and tells the students that she will fail them in their assessments, to encourage them to try harder.

Dr Violet also insists that the students make her coffee and go out to buy her sandwiches for lunch.

There are a number of reports from students that they feel intimidated by her although no formal complaints have been made.

On one occasion two months ago, two attached students became distressed, as they felt that Dr Violet had been rude to a patient.

Dr Violet had also examined a male patient's genitalia in front of the two female students in a manner they felt was disrespectful, without any discussion of chaperones. The patient in question did not complain to the hospital.

That same month the same students accompanied Dr Violet on a ward round where another intimate examination on a male patient was performed without any consent or explanation. When one of the students queried this with Dr Violet, she sent them both home and instructed them never to return to the hospital.

Dr Violet wrote to the course organiser at the university stating that the students were the worst that she had ever encountered and that she was refusing to sign them off for their attachment. As a result, both students had to attend a progress committee hearing.

The Dean of the Medical School contacted the Responsible Officer (RO) to tell him that the students say Dr Violet is bullying them.

The RO also receives a letter from the General Medical Council, asking for information about Dr Violet following a patient complaint that an intimate examination had been undertaken with neither dignity nor consent. The procedure had also caused pain, for which Dr Violet had refused to apologise.

The RO knows that there have been verbal complaints from the administrative staff about Dr Violet's over obsessive attention to detail and concerns that she has been arriving at the hospital at 05:00 to go through patient files.

The RO immediately spoke to Dr Violet about all these allegations and she admitted she had been stressed and felt ill.

The RO referred Dr Violet to occupational health who confirmed she was fit for work.

Questions to consider

- Are there any conflicts of interest for the Case Manager (CM) to consider when appointing the Case Investigator (CI)?
- The CM has appointed you to be the CI for this case and given you the following ToRs – what critiques do you have?

The matters to be investigated are:

ToR 1: To review how Dr Violet treats male and female patients with dignity and respect and how she ensures consent

ToR 2: To review why Dr Violet was accused of bullying by the students

ToR 3: To review why Dr Violet is working such long hours

ToR 4: To review potential factors of Dr Violet's health, which may be causing her stress

Resolution

Case investigator training workshop

Workshop B.2: Critiquing Terms of Reference (Dr Purple)
England / Secondary Care
DELEGATE VERSION

Dr Purple is a 59 year old cardiologist. He had been considered difficult to manage by all the clinical directors who have tried over the last 20 years. Previous clinical directors have considered him to be opinionated and rude, both to nursing staff and to junior doctors.

A new clinical director, Dr Maroon, was appointed two months ago and within one week had received a patient complaint about Dr Purple shouting on the ward rounds.

A trainee, Dr Orange, has reported that Dr Purple told her that she was hopeless at performing temporary pacemaker insertions and that she would never make a cardiologist. She was upset and made a complaint to the Director of Education. Dr Maroon spoke to Dr Purple and asked him to try to be polite to staff – Dr Purple apologised and said that he had not recognised his behaviour was causing offence.

In the last fortnight Dr Maroon has been called twice to help Dr Purple in the catheter lab with two cases – once when Dr Purple was having difficulty finding vascular access and secondly when he had difficulties with a pacemaker insertion. Dr Maroon raised an incident notification about the pacemaker insertion.

Dr Maroon is aware that the nursing staff are of the view that Dr Purple is not a team player and can be disruptive and dismissive.

In the past week it was alleged that Dr Purple did not dispose of sharps correctly whilst in the catheter laboratory. Staff Nurse Red sustained a needle stick injury and had to attend A&E for management of the injury. During the incident, Dr Purple told her she should be more careful when cleaning the tray up after him. The hospital policy states that the user of a sharp should place it directly in the sharps bin. She reported this to her manager and completed an incident form.

The Medical Director, Dr Mauve, who is new to the Trust in the last 12 months, received the incident form and asked to see Dr Purple along with the HR Director. Dr Purple did not deny his behaviour towards other staff, but emphasised that no-one had complained before.

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

Dr Mauve discussed the case with the HR Director and it was agreed to commission a full investigation as a member of staff had been harmed. Currently Dr Purple is continuing to work and there are no concerns about his health.

Questions to consider

- Are there any conflicts of interest for the Case Manager (CM) to consider when appointing the Case Investigator (CI)?
- The CM has appointed you to be the CI for this case and given you the following ToRs – what critiques do you have?

The matters to be investigated are:

ToR 1: To review how Dr Purple works with colleagues and why he is not polite

ToR 2: To review why Dr Purple cannot follow the Trust's policy on disposal of sharps

ToR 3: To review the facts around the incident in which Staff Nurse Red sustained a needle stick injury and was referred to A&E for screening

- What issues do you want to consider with the CM before starting this investigation?

NHS Resolution

Case investigator training workshop

Workshop C: Index of evidence
England / Secondary Care
DELEGATE VERSION

Date obtained	Source	Item	Notes	ToR reference	Further information needed

NHS Resolution

Case investigator training workshop

Workshop C.1: Critiquing Terms of Reference
England / Secondary Care
DELEGATE VERSION

Terms of reference

Organisation's investigation case reference number: *[XXX]*

An investigation has been commissioned into the performance of Dr Purple working as a Consultant Cardiologist for St Elsewhere University Teaching Hospital at St Elsewhere Hospital, University Lane, Blackheath HH1 2JK.

Case manager: Dr Mauve

Case investigator(s): Dr Neon

Undisputed facts

Detail undisputed facts relevant to the investigation [ADVISER NEEDS TO COMPLETE]

Terms of Reference (ToRs)

The matters to be investigated are:

TOR1. the circumstances around the incident where a member of staff sustained a needle stick injury in the cardiac catheter laboratory on 14/11/16 (incident no 1462)

TOR2. the circumstances related to the patient complaint about shouting at staff on wards on 18/11/16

TOR3. the circumstances related to the complaint from the trainee about Dr Purple on 19/11/16 stating she will never make a cardiologist

TOR4. the circumstances related to the two incidents in the catheter laboratory:

a. patient no 12345 where vascular access was difficult to find 07/01/17
b. patient no 67893 where there was difficulty with a pacemaker insertion 12/01/17.

These ToRs may need to be amended during the investigation by the Case Manager, amendments will be shared with the practitioner with explanation.

Timescales

It is expected that the investigation will be completed by 16/03/17 and that a report will be submitted to the case manager by 23/03/17

Methodology

[ADVISER NEEDS TO COMPLETE]

Witnesses to be interviewed

This section should detail list of witnesses to be interviewed – names, job titles and organisation. If available include witness interview timetable. [ADVISER NEEDS TO COMPLETE]

This list does not prohibit the case investigator from interviewing other witnesses who they think are relevant during the course of the investigation, this would need to be agreed by the case manager.

Documentary evidence

The following information has been provided by the case manager for the case investigator to consider:

- St Elsewhere's policy on disposing of sharps directly
- NICE guidelines on disposing of sharps directly
- St Elsewhere's policy on dignity at work
- incident report no 1462 (needle stick injury)
- complaint letter from patient dated 18/11/16
- complaint from trainee dated 19/11/16
- complaint from Director of Medical Education dated 24/12/16
- Incident notification: 12345 (Vascular access was difficult to find)
- Incident notification: 67893 (Difficulty with pacemaker insertion)
- St Elsewhere's Needle Stick Injury Report for FY15/16.

This list does not prohibit the case investigator from seeking additional documents which may become relevant during the course of the investigation, this would need to be agreed by the case manager.

Report expectations

The report will detail the investigation's summary and analysis of evidence, including, where there are issues of capability, evidence on how the performance of Dr Purple compares with that expected from a practitioner working in similar circumstances.

Agreed by	Decision Making Group (Medical Director and HR Director)

Date	19/01/17
Signed on behalf of	Decision Making Group by Dr Mauve
Signature	Dr Mauve
Date	20/01/17
Seen and read by	Dr Purple
Signature	Purple
Date	20/01/17

Resolution

Case investigator training workshop

Workshop C.2: Sharps policy
England / Secondary Care
DELEGATE VERSION

St Elsewhere's policy on disposing of sharps directly

Approved: ICC July 2016 Next review date: June 2018

AT ALL TIMES, STAFF MUST TREAT EVERY INDIVIDUAL WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1. AIM

To ensure that sharps are used and disposed of safely within St Elsewhere's Hospital Trust. This guidance supports and underpins the operational effectiveness of minimising sharps injuries. This guidance also supports the Occupational Health policies: Policy on the Post-exposure Prophylaxis for Healthcare Workers Occupationally Exposed to HIV and Guidance on the Prevention and Management of Body Fluid Exposures.

2. SCOPE

This document applies to all Health Care Workers working within St Elsewhere's Hospital Trust and is to be adopted as general practice.

3. INTRODUCTION

For the purpose of this document a 'sharp' is defined as anything which may puncture skin and which may be contaminated by blood or other body fluids. This includes cannulae, giving sets, as well as hypodermic needles and syringes, suture needles and scalpel blades from hospital setting.

It is the responsibility of managers and all members of staff to safeguard the health of the patients, other members of staff and themselves by complying with the Duty of Care Code of Practice, Environmental Protection Act, 1990 and Department of Health, Saving Lives, High Impact Interventions No 1. Failure to comply with this document could result in prosecution under the Health and Safety at Work Act, 1974 and the Control of Substances Hazardous to Health Regulations, (Microbiological Hazards), 2002).

4. GUIDELINES

4.1. Clinical sharps should be single-use/single patient use only.

4.2. All sharps including hypodermic needles, suture needles, cannulae, scalpel blades etc. must be discarded directly and immediately into a sharps disposal container, at point of use. Sharps container must comply with BS 7320:1990 'Specification for sharps containers' and be of the appropriate size for its purpose. Sharps trays should be obtained to help contain clinical items.

4.3. Do not dispose of sharps with other clinical waste in a clinical waste bag or in such a way that they are likely to cause injury, i.e. in the laundry with the patient's linen, or in anything other than a sharps container.

4.4. Needles must not be re-sheathed prior to disposal. Needles must not be bent or broken prior to use or disposal. NB: Needles that require unscrewing prior to disposal i.e. dental, cytology needles – only staff that have been taught and are competent to re-sheathe prior to removal should do so.

4.5. In general, it is the responsibility of the person(s) using the sharp to dispose of it properly. Do not leave sharps for someone else to dispose of.

4.6. In the rare circumstance that blood needs to be transferred from syringe into a specimen bottle extreme care must be taken when removing the needle from the syringe. The needle should be discarded directly and immediately into the sharps container.

4.7. Follow the manufacturers' instructions when assembling sharps containers taking particular care to ensure that the lid is properly fastened into position prior to use.

4.8. Write the area, e.g. Ward/department, in which the sharps container is used, on the label attached to the container with an indelible marking pen. Labels should also be signed and dated at appropriate times (assembly, closure and disposal) then tagged and stored in locked area away from public access to await disposal, to comply with Controlled Waste Regulations, 1992 and 1999 guidance.

4.9. Sharps containers must be readily available in any area where sharps are likely to be used e.g. medicine trolley and cardiac arrest trolley. For procedures where sharps are used at the bedside, a sharps container must be available so that the sharp can be discarded directly and immediately into the sharps container after use.

4.10. IV giving set injection sharps must be cut (below the drop counter) and disposed of into a sharps container. The remaining sharp-free tubing can be safely disposed of into a clinical waste bag.
NB. Any remaining drug should be discarded.

4.11. Used sharps must never be carried in a receiver or on a tray they must be disposed of directly and immediately into a sharps container (as near to usage as possible).

4.12. Sharps containers must never be placed at floor level. They should always be placed out of the reach of children and where unauthorised people cannot gain access to them when not in use.

4.13. It is the duty of the person in charge of the area to carry out a risk assessment to determine the safest places for sharps containers to minimise the risk of injury.

4.14. The sharps container must remain in a designated place, except when it is being used by a health care worker, and therefore is under supervision.

4.15. Staff who need to transport sharps boxes within the community should ensure that they are transported safely.

4.16. Do not attempt to retrieve any items from sharps containers.

4.17. Do not attempt to press down on the sharps to make more room in the sharps container – or shake the box.

4.18. When needles and syringes have been used on a patient and may potentially be contaminated with blood, the needle and syringe should be disposed of as one unit into a sharps container and not disconnected from each other.

4.19. Sharps must be put into the sharps container and not left protruding from the container or left on top or lying around the outside of the container.

4.20. Do not fill sharps containers above the manufacturers marked line. Check the sharps container before use to ensure it is not overfilled.

4.21. Lock the used sharps container when ready for final disposal (i.e. when the manufacturers marked level is reached or at intervals as specified by local procedures) using the locking mechanism on the closure.

4.22. Handle used sharps containers with extreme care, especially when being moved or transported.

4.23. Do not place used sharps containers ready for disposal into yellow bags or any other bags.

4.24. Keep temporary closure in place when sharps box not in use.

5 SHARPS INJURY

Immediately following an injury with a used sharp, bleeding should be encouraged and the area washed under running water, then you immediately follow the procedure for exposure to blood-borne viruses (see Occupational Health Policy).

6 REPORTING OF INCIDENT

All staff injuries should be reported in accordance with the Trust policies on Post-Exposure Prophylaxis for Healthcare Workers Occupationally Exposed to HIV and Management of Body Fluid Exposures.

7 AUDITING

The operational effectiveness of this guidance will be audited with the Infection Control Quality Monitoring Programme on an annual basis and the result fed back to the Infection Control Committee, Clinical Governance Committee and the Professional Advisory Board.

Resolution

Case investigator training workshop

Workshop C.3: NICE guidelines
England / Secondary Care
DELEGATE VERSION

NICE guidelines on disposing of sharps directly

Selection from *Infection control prevention of healthcare-associated infection in primary and community care June [2003, amended 2012]*

Section 1.1.4

1.1.4 Safe use and disposal of sharps

1.1.4.1 Sharps should not be passed directly from hand to hand, and handling should be kept to a minimum. **[2003, amended 2012]**

1.1.4.2 Used standard needles:

- must not be bent or broken before disposal
- must not be recapped.

  In dentistry, if recapping or disassembly is unavoidable, a risk assessment must be undertaken and appropriate safety devices should be used. **[new 2012]**

1.1.4.3 Used sharps must be discarded immediately by the person generating the sharps waste into a sharps container conforming to current standards. **[new 2012]**

1.1.4.4 Sharps containers:

- must be located in a safe position that avoids spillage, is at a height that allows the safe disposal of sharps, is away from public access areas and is out of the reach of children
- must not be used for any other purpose than the disposal of sharps
- must not be filled above the fill line
- must be disposed of when the fill line is reached
- should be temporarily closed when not in use
- should be disposed of every 3 months even if not full, by the licensed route in accordance with local policy. [new 2012]

1.1.4.5 Use sharps safety devices if a risk assessment has indicated that they will provide safer systems of working for healthcare workers, carers and patients. **[new 2012]**

1.1.4.6 Train and assess all users in the correct use and disposal of sharps and sharps safety devices. **[new 2012]**

Resolution

Case investigator training workshop

Workshop C.4: Dignity at work policy
England / Secondary Care
DELEGATE VERSION

St Elsewhere's policy on Dignity at work

TRUST POLICY AND PROTOCOL FOR DIGNITY AT WORK AND THE MANAGEMENT OF HARASSMENT & BULLYING

Version	6
Name of responsible (ratifying) committee	HR Policy Group
Date ratified	7 February 2016
Document Manager (job title)	Operational HR Manager
Date issued	15 August 2016
Review date	January 2019 (unless requirements change)
Electronic location	HR Policies
Related Procedural Documents	Fair Treatment & Grievance Policy; Staff Discipline Policy; Equality & Diversity Policy; Whistleblowing Policy; Essential Training Policy, Social Networking guidance 2010
Key Words (to aid with searching)	Dignity at work; Harassment; Bullying; Respect; Mediation; Equal opportunities; Victimisation; Staff attitudes;
In the case of hard copies of this policy the content can only be assured to be accurate on the date of issue marked on the document. For assurance that the most up to date policy is being used, staff should refer to the version held on the intranet	

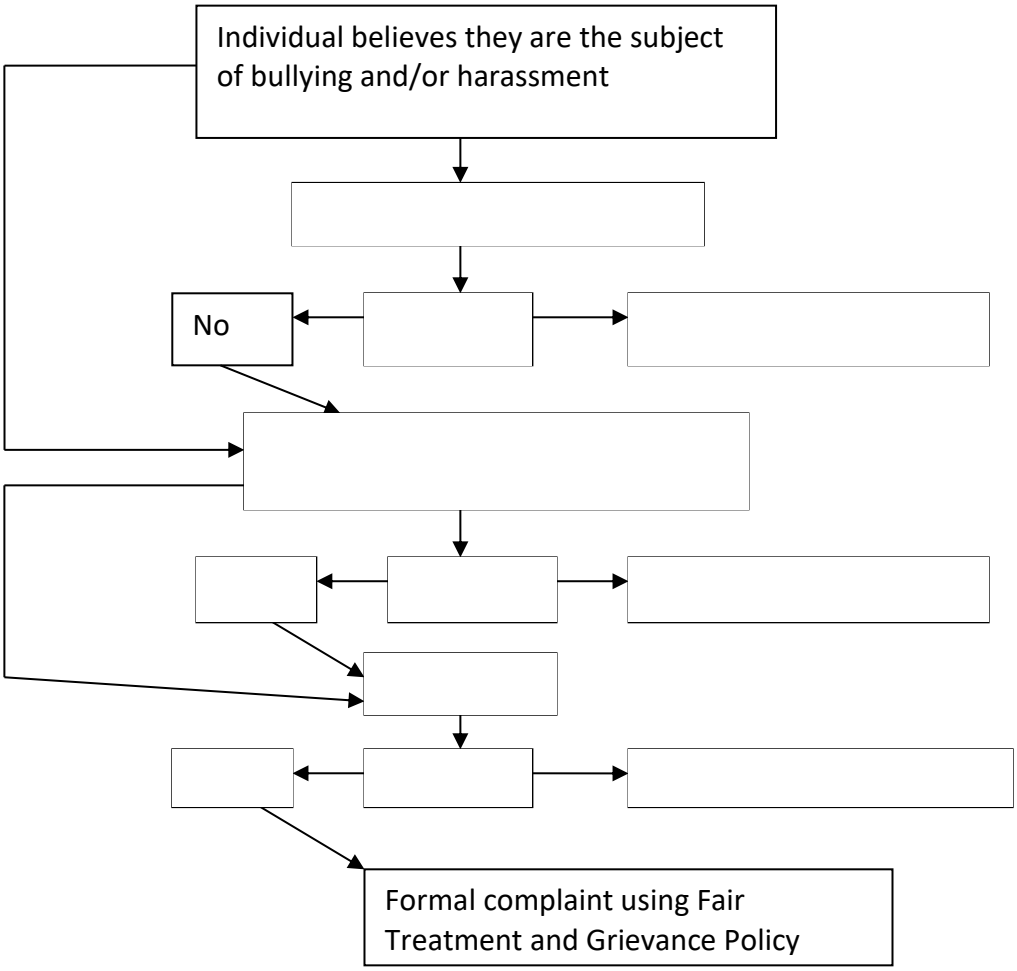
This Policy is designed to raise awareness amongst all Trust employees about harassment and bullying, the behaviours that constitute each and that behaviour of this kind will not be tolerated. It is also designed to provide a mechanism for dealing with allegations of harassment and/or bullying.

For quick reference the guide below is a summary of actions required. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy.

1. Initially, wherever possible, should an individual employee believe they are being subjected to harassment and/or bullying at work, an informal approach to resolution should be sought.

2. As part of the informal process, the Staff Mediation service can be involved to provide mediation to attempt to resolve the issues.

3. Where informal attempts to resolve the situation are unsuccessful, the formal stages of the Trust's Grievance and Fair Treatment Policy should be followed.



INTRODUCTION

1.1 As an equal opportunities employer and an organisation with a diverse workforce, St Elsewhere's Hospitals NHS Trust ("the Trust") supports a working environment for individuals in which dignity at work is paramount. The Trust is committed to creating a working environment and culture which is free from any form of bullying or harassment and which, as a consequence, will enable all employees to contribute more effectively, achieve higher levels of job satisfaction and perform to the best of their ability.

1.2 The Trust recognises that all employees have the right to be treated with consideration, dignity and respect whilst at work. The Trust seeks to support staff in their working life and aims to provide a positive and fulfilling environment in which to work. This policy promotes the respectful treatment of staff within the Trust and the protection of Trust employees from bullying and harassment at work. Bullying and harassment will not be tolerated by the Trust in any form.

1.3 This policy has been written in the spirit of the NHS Constitution.

PURPOSE

2.1 The purpose of this policy is to:

- Raise awareness amongst all employees that harassment and bullying of any kind will not be tolerated;
- Provide definitions of what constitutes harassment and bullying, as well as the positive behaviours the Trust requires all employees to display;
- Provide a mechanism for dealing with allegations of harassment, bullying or intimidation.

2.2 Each member of staff has a personal responsibility for their own behaviour and is responsible for ensuring that their conduct is in line with the standards set out in this policy.

SCOPE

3.1 This policy covers all employees of the Trust, including Medical & Dental Staff, regardless of role, location or contractual status.

3.2 The Trust also expects volunteers, those attending the Trust for work experience, contractors and any others working on the Trust's premises or on its behalf to comply with this policy. Failure to do so may result in the working arrangements being terminated.

3.3 When handling any allegations raised by employees, the following guiding principles will always apply:

- **Fairness and equity** – anyone raising allegations will be treated fairly and equitably. Any employee should feel free to raise valid allegations and should be reassured that they will not be victimised for doing so or for acting as a witness for another complainant.
- **Resolution of issues as informally as possible** – it is in the interests of all parties that any complaints raised are resolved at the earliest opportunity.
- **Timely resolution** – where allegations have been raised, these will be dealt with in a timely manner.
- **Organisational learning** – the Trust will continually seek to learn and improve from any allegations and complaints raised.

3.4 Allegations raised regarding bullying and harassment will be taken seriously and treated confidentially. The Trust gives assurance that there will be no victimisation against an employee making a complaint or against employees who assist or support a colleague in making a complaint.

3.5 Bullying and harassment may be treated as disciplinary offences and, where allegations are founded, may lead to disciplinary action, including summary dismissal. This will be dealt with under the Trust's Discipline for Staff Policy. Disciplinary action may also be taken if allegations are found to have been made maliciously or vexatiously. The posting of inflammatory or defamatory comments about patients, colleagues, the Trust on social networking sites / blogs or other internet forums shall constitute harassment and therefore will be dealt with under the Trust's disciplinary policy.

3.6 Confidentiality

3.6.1 All complaints of harassment and bullying will be treated sensitively and in confidence. This extends to information about, or provided by, the alleged harasser, complainant, representatives and any witnesses involved, either prior to or during any investigation or subsequent proceedings.

3.6.2 However there may be occasions where the alleged behaviour is deemed to be extremely serious, for example a threat of physical violence, and on these occasions, the Trust may consider taking action without the express agreement of the complainant and undertake a full investigation.

3.6.3 In certain circumstances, where illegal or dangerous practices are revealed, it may be necessary to disclose details of the case to a relevant authority, or where the behaviour of the harasser is considered to amount to a criminal offence, the complainant may be advised to contact the police. This will not preclude the Trust undertaking its own investigation.

In the event of an infection outbreak, flu pandemic or major incident, the Trust recognizes that it may not be possible to adhere to all aspects of this document. In such circumstances, employees should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety.

DEFINITIONS

4.1 Positive Behaviours

The following are examples of the positive behaviours, which the Trust requires:

- Mutual helpfulness, understanding and trust;
- Respect for different backgrounds and talents;
- Respecting confidences;
- Understanding someone else's point of view/displaying empathy;
- Doing what you say you will do;
- A high level of rapport, openness and honesty with each other;
- Straightforward communication;
- Giving constructive feedback;

- Creative and collaborative problem solving;
- Willingness to work through conflict and disagreement.

These qualities should form the basis of interpersonal relationships in the Trust and should facilitate both enhanced performance and improved working lives for all.

4.2 **Harassment**

4.2.1 Harassment can take many forms and may be directed against males or females, ethnic minorities or towards people because of their age, sexual orientation, physical or mental disability, religion or belief, or some other characteristic. It may involve action, behaviour, comment or physical contact which is found to be objectionable by the recipient or which causes offence and can result in the recipient feeling threatened, humiliated, patronised or isolated. It can also create an intimidating work environment.

4.2.2 Individual perceptions about certain types of behaviour will vary, so what is acceptable for one person, may be inappropriate or unacceptable behaviour to another. Harassment may be persistent or occur on a single occasion. It may be intentional or unintentional on the part of the perpetrator, but it is the impact of the behaviour on the recipient, and the deed itself, which constitutes harassment.

4.3 **Bullying**

4.3.1 Bullying can be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient.

Both bullying and harassment may be carried out by an individual against an individual or involve groups of people. They may be obvious or insidious. Whatever form they take, such behaviour is unwarranted and unwelcome to the recipient. The following are examples of unacceptable behaviours that can be considered to constitute bullying or harassment:

- Humiliation or ridicule by comment or gesture;
- Unwanted physical contact;
- Inappropriate comments about appearance or clothes, outside the Trust's Dress Code;
- Display or circulation of sexually suggestive material;
- Derogatory, threatening or intimidating remarks or behaviour;
- Ignoring, marginalizing or excluding another employee;
- Belittling, ridiculing or threatening;
- Public or constant destructive criticism;
- Verbal abuse and spreading unfounded rumours;
- Setting unrealistic targets which are unreasonable or changed with limited notice or consultation.

The list is not intended to be exhaustive.

DUTIES AND RESPONSIBILITIES

5.1 **Individual Employees**

5.1.1 Employees are responsible for ensuring that their conduct and behaviour are in line with the standards set out in this policy.

5.1.2 If an employee raises an allegation of bullying or harassment, or has been accused of either of these, they are expected to contribute to the resolution in a positive, timely and constructive manner.

5.1.3 If mediation is agreed as an attempt to resolve the matter, employees will be expected to participate, cooperate and engage with the mediation process as fully as required in order to give it as much opportunity for success as possible.

5.1.4 Employees must not use this policy to raise frivolous issues or raise concerns in a vexatious or malicious manner.

5.1.5 Where an employee witnesses any acts which may constitute bullying and/or harassment, they should report this to their line manager in the first instance.

5.2 Managers

5.2.1 Managers are responsible for bringing the provisions of this policy to the attention of their staff and ensuring that their staff understand which behaviours are acceptable and not acceptable in the work place.

5.2.2 Managers are responsible for ensuring that any allegations raised with them are taken seriously and are dealt with in a fair, timely, supportive, constructive and appropriate manner and dealing with any outcomes appropriately.

5.2.3 Where an action plan has been agreed, managers are responsible for ensuring that the actions are carried out appropriately.

5.2.4 Managers should set a good example by treating all staff with dignity and respect.

5.3 Elected Staff and Trade Union Representatives

5.3.1 The role of the elected staff and trade union representative is to act as an advocate for the employee raising allegations of bullying and harassment and provide support through the initiation of this policy. They will only do this if invited to do so. They may also act as an advocate and support for any employee who has allegations of bullying and harassment raised against them. However, the same representative may not act for both parties.

5.3.2 Elected staff and trade union representatives are responsible for assisting with seeking resolutions in a timely and constructive way.

5.4 Workforce and Human Resources

5.4.1 The Workforce and HR Directorate will, through the Operational HR team, be responsible for advising all parties on this policy and for providing specific management and staff guidance.

5.4.2 The Operational HR team will be responsible for monitoring each active case to ensure appropriate and timely management.

5.4.3 It is important that learning from allegations raised takes place across the Trust. A member of the Operational HR team will write up the learning of the case review in the form of case studies and this will help to inform the training of managers in the handling of allegations of bullying and harassment. Reference to individuals or easily identifiable situations will be anonymised.

5.5 Equality and Diversity for Staff Committee

5.5.1 The Equality and Diversity for Staff Committee will be responsible for examining statistics to monitor any developing trends in complaints of bullying and/or harassment.

5.5.2 The committee will also be responsible for receiving reports prepared by the HR Manager, Recruitment, the Equality and Diversity lead and the Operational HR Manager/Operational HR Team and for taking actions on any identified deficits.

5.6 Mediators

5.6.1 Mediators are responsible for assisting parties in resolving disputes.

PROCESS

6.1 INFORMAL PROCEDURE

6.1.1 An employee who believes they are the subject of harassment or bullying may wish to keep a diary of the details. This should include the details of the incident, date, time, place, their feelings at the time, their reactions to the incident, the reactions of the person considered to be harassing them and details of any witnesses to the incident.

6.1.2 Many complaints of harassment or bullying can be dealt with informally. This approach can result in speedy resolutions and be beneficial to all parties concerned. In many circumstances, an informal approach may be all that is required to stop the behaviour causing offence, particularly if the perpetrator is unaware of the effects of their actions.

6.1.3 The informal approach can be undertaken in a number of ways:

- The issue can be raised directly with the alleged harasser, by the employee, either in writing or verbally;
- The issue can be raised directly with the alleged harasser, by the employee, with support;

- The issue can be raised directly with the alleged harasser's manager, again with or without support.
- Facilitated meeting between the two parties to allow both to express their points of view. The meeting will be facilitated by the employee's line manager or the line manager's manager.

6.1.4 The informal approach provides an opportunity for the employee to inform the alleged harasser that certain behaviours and actions are unacceptable to them and that the behaviours and actions must stop.

6.2 MEDIATION

6.2.1 If the employee feels unable to deal directly with the alleged harasser, then as part of the informal procedure, trained Mediators may be involved. The Trust operates a Staff Mediation service, available to all employees. This is an informal, voluntary process, which it is hoped will avoid the need for more formal processes. Mediation helps individuals to understand what has happened and why and enables them to exchange feelings and to communicate respectfully. It is a constructive, confidential, step by step process, facilitated by neutral, trained Mediators. Both parties need to be open to and agree to the mediation process in order for it to be an option. However it is highly recommended that mediation is attempted wherever possible, and at an early stage in the process. All members of the mediation team are self-employed and fully trained in mediation techniques.

6.2.2 A Mediator will normally meet with each of the parties individually before advising on the next steps of the mediation process. Possible options would include a further meeting between both parties, facilitated by the mediators. At this meeting the complainant will be given the opportunity to explain to the alleged harasser the reasons why they consider their behaviour to constitute harassment or bullying. Where possible the matter will be resolved through informal discussion and agreement about future behaviour. Further meetings may be required to ensure each party is committed to the agreement and to build up the working relationship. Progress will be monitored following the mediation.

6.2.3 Any member of Trust staff may request Mediation, as well as managers requesting it for members of their team. The Operational HR team and Trade Union and staff side representatives may also identify situations where Mediation may be of value and make referrals accordingly. The Mediation service can be contacted on (023) 9228 3248.

6.2.4 Members of the Operational Human Resources Team may be involved to facilitate this process where required.

6.3 FORMAL PROCEDURE

6.3.1 Where informal attempts to resolve the situation have not been successful, or the complainant feels the acts complained of may not be resolved informally or through mediation, the formal stages of the Trust's Grievance and Fair Treatment Policy should be followed. It is important, however, that the informal processes have at least been considered before this step is taken.

6.3.2 Allegations that are founded may result in the Trust's Staff Discipline Policy being instigated against the alleged perpetrator.

6.4 SUPPORT AND ADVICE

6.4.1 The Trust is committed to achieving informal resolution of complaints relating to harassment and bullying wherever possible. In line with this approach, there are several options available to enable employees to be supported. This support will be provided not only to complainants, but to alleged perpetrators and any witnesses.

6.4.2 Counselling Service (Aquilis)
The Trust provides a free, confidential and impartial counselling service for all employees. All counsellors are self-employed, independent, appropriately qualified and members of the British Association for Counselling and Psychotherapy. The counselling service can be contacted on (023) 9286 6402, a confidential voicemail number, or alternatively through the Occupational Health and Safety Department.

6.4.3 Occupational Health and Safety Service
Any member of staff who is involved in a claim of bullying or harassment may find it helpful to talk to the Occupational Health and Safety Service. All employees are able to self-refer to Occupational Health. They can be contacted on (023) 9275 3346.

6.4.4 Trade Union and Staff Side Representatives
The Trust recognizes the important role such representatives play in addressing bullying and harassment and employees are encouraged to approach their representative regarding their concerns. The Trust will work in conjunction with Trade Union and staff side representatives in addressing unacceptable and inappropriate behaviours.

6.4.5 Trust Mediation Service
See section 6.2 above.

6.5 FOLLOW UP

6.5.1 Following resolution of both formal and informal allegations of bullying or harassment, the Operational HR Team will keep a record of the incident. Where harassment or bullying did occur, it is important to ensure that the behaviours have now ceased, that there has been no subsequent victimisation and that any agreed action plans have been carried out and completed. Monitoring of each active case will be carried out on a regular basis by the Operational HR Team.

TRAINING REQUIREMENTS

7.1 Training forms part of the Trust's Essential Skills and Training Requirements; as identified in the Training Needs Analysis. It is included in mandatory Corporate Induction and in Essential Updates

7.2 Staff attend classroom delivered Essential Update training every three years and undertake refresher training via the ESR system in the intervening years

7.3 All training is recorded on the Electronic Staff Record (ESR) from which the Learning and Development Team provide a monthly heat map to each CSC, to enable monitoring of compliance

7.4 Compliance is further monitored through the CSC performance reviews with the Executive Team

REFERENCES AND ASSOCIATED DOCUMENTATION

- ACAS advice leaflet: Bullying and harassment at work
- ACAS Code of Practice: *Disciplinary and Grievance Procedures*
- ACAS guide: Discipline and Grievances at Work
- *Bullying at Work: Beyond policies to a culture of respect:* CIPD 2005 http://www.cipd.co.uk/subjects/dvsequl/harassmt/bullyatwork0405.htm
- Employment Act 2008
- Social Networking Guidance 2012

EQUALITY IMPACT STATEMENT

St Elsewhere's Hospital NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly

NHS Resolution

Case investigator training workshop

Workshop C.5: Incident form (Needle stick)
England / Secondary Care
DELEGATE VERSION

Incident notification 1462 (Needle Stick Injury)

St Elsewhere's Hospital NHS Trust
INCIDENT/NEAR MISS REPORTING FORM (Clinical and Non-Clinical)

DOCUMENT FACTS ONLY PLEASE WRITE CLEARLY

Amber/Red incidents **must** be reported immediately to your Line Manager **and** to the Risk Information Team on **x1234**

Details of Person Involved in the Incident

Full Name: Staff Nurse Red

Address: **Cardiovascular Department, St Elsewhere's Hospital, University Lane, Blackheath**

Date of Birth **12/01/78** **Post Code** **HH1 2JK**

Gender: **Female** **Ethnicity:** **Welsh** (NPSA Requirement)

Consultant (if patient): **Job Title (if staff):**

NHS Number:

Staff/Patient Number:

Person Type
❒ Staff Member

Date of Death:

Incident Date	**Department / Ward Reporting The Incident**	**Specific Location: (e.g. bathroom)**
14/11/16	Cardiovascular Department	Cardiac Catheter laboratory

Incident Time	**Site where inc. Occurred**	**Department/Ward where inc. Occurred**	**Bay No:** **Bed No:**
16:35pm	Catheter Lab		

Description of Incident (e.g. events before, during and after)

PLEASE WRITE CLEARLY AND AVOID JARGON / ABBREVIATIONS

Please include any relevant screening tool score (e.g. Waterlow, nutritional screening, etc)

I was clearing the treatment trolley after the final procedure of the day and as I lifted the kidney dish I felt a sharp prick in my right middle finger. A needle had fallen out of the dish and onto the theatre sheets and I hadn't seen it. The needle should have been disposed of in the sharps bin by Dr Purple, consultant cardiologist, so I told him and he said I should have taken more care. This has happened twice before BUT this is the first time I have had an injury.
I am concerned as I think the patient had previously been an intravenous drug abuser

-continue overleaf-

If medication incident, please state drug involved	**Correct Drug**	**Drug Given (If Wrong Drug)**	**Is this a controlled drug** Yes ☐ No ☐

Did injury occur? Yes [X] No ☐	**Description of Injury**	**Patient Falls Assessment Score** Pre Incident ☐ Post Incident ☐	**Pressure Sore/Ulcer Grade** ☐
	Needlestick to right middle finger		

If reporting a fall please tick the relevant section if the fall occurred as a result of one of the following	**The floor was being cleaned at the time of fall** Yes ☐ No ☐	**Due to a defect to the flooring** Yes ☐ No ☐	**Due to liquid or other contamination present on the floor** Yes ☐ No ☐

Was any member of staff absent for 3 or more days as a result of the incident?

Yes ☐ No ☐ **First Date of Absence:** **Date Returned to Duty (if known):**

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NHS Resolution

Was any medical equipment involved?	Details of Equipment (include serial number if known)	Has the equipment been removed from service?
Yes ☐ No ☐	.....	Yes ☐ No ☐

Other Person(s) Involved/Witnesses		Flexibank?
1. **Staff Nurse Red**	Job Title: Staff Nurse ..... Ext/Bleep:	Yes ☐ No ☐
2. **Dr Purple** ..... Cardiologist	Job Title: Consultant Ext/Bleep:	Yes ☐ No ☐

Support offered to staff? (please circle)	Is the patient aware of incident? (please circle)	Was this a near miss? (please circle) If 'Yes' complete 'Near Miss Score'
N	Y / N	Y / N

Please use Risk Scoring Method to score all incidents

Actual Score	Near Miss (Potential) Score
Consequence Score (C): 4 (L) Likelihood Score: 1 → Risk Score (C x L) = 4	Consequence Score (C): ☐ (L) Likelihood Score: ☐ → Risk Score (C x L) = ☐
Method Descriptor Used to Identify Consequence Score	

Incident Form Completed By *(all of this section must be completed)*			Flexibank?
Print Name Staff Nurse Red	Signature	Date **14/11/16**	Yes ☐ No X
Job Title	Ward/Dept	Ext/Bleep	

Follow up to be taken by: – Green (Ward / Department Manager), **Yellow** (Matron / Section Head), **Orange or Red** (Lead Nurse / HS&W Team)

Please give brief details of action taken including any support given to staff: .....

I sent the staff nurse to A&E for screening and I have asked the risk management department to undertake a root cause analysis. I have reported to Health and Safety Manager. .....

.....

.....

Print Name: Mrs G Greenbank ..... **Signature:** .....

Job Title: Manager Cardiovascular Department ..... **Ext/Bleep:** ..... **Date:** 14/11/16 .....

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

NHS Resolution

The Risk Scoring Method should be applied to all incidents, complaints, claims and risks identified through proactive risk assessments.

1. **Consequence:** Use **Table 1** to determine the Consequence Score(s) **C**. In the case of incidents, complaints and claims, this is the **actual** consequence (i.e. what actually happened). In the case of proactive risk assessments, it is the potential consequence (i.e. what could potentially happen). All events, actual or future, may have one consequence or several consequences (e.g. affecting patient care, financial impact, adverse publicity, etc). **The score used to calculate the overall consequence is the row from which the highest numerical score is achieved.**

2. **Likelihood:** Use **Table 2** to determine the Likelihood Score **L**. This is the chance that the consequence described above will occur (or recur) to that identified group.

3. **Risk Score:** See **Table 3**. Multiply the Consequence Score **C** with the Likelihood Score **L** to obtain the Risk Rating, which should be a score between 1 and 25.

4. **Near Miss:** Please tick the Near Miss box if applicable. All 'near miss' incidents are to be scored twice; Once for what actually happened and then for what would have happened had intervention not taken place.

5. Orange and Red incidents must be reported to Risk Management on ext. 1234 immediately

6. Root Cause Analysis (RCA) **must** be undertaken for all red/orange incidents and claims. Inform your Line Manager if you feel that an incident, complaint or claim is likely to attract media attention. RCAs **must** be completed within **25 working days (5 working days for MRSA bacteraemia cases)**.

Table 1 – Consequence

Actual Severity = Incidents / Complaints / Claims **Potential Severity = Risk Assessments/Near Miss**

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention, will probably resolve within one month Staff injury requiring time off work or light duties for 3 days or less Hospital acquired **colonisation** affecting one or more patients, member of staff or the public	Moderate injury, ill health, damage or loss of function Staff injury requiring time off work or light duties for 4 – 35 days Hospital acquired **infection** affecting one or more patients, members of staff/the public or where a bay closure occurs	Major injuries leading to long-term incapacity/disability Major injuries/Dangerous Occurrences reportable under RIDDOR Requiring time off work or light duties for >36 days with eventual recovery Unexpected admission to critical care area with eventual recovery MRSA Bacteraemia with eventual recovery Hospital acquired **infection** affecting > 1 bay	Unexpected death or significant permanent disability where outcome is directly attributable to a safety incident All Never Events* (See list below) Part 1 of death certificate stating hospital acquired infection Hospital acquired **infection** affecting > 1 ward
Objectives / Projects	Insignificant project slippage Barely noticeable reduction in scope or quality	Minor project slippage Minor reduction in scope or quality	Serious overrun on project Reduction in scope or quality	Project in danger of not being delivered Failure to meet secondary objectives	Unable to deliver project Failure to meet primary objectives
Service / Business Interruption	Loss / Interruption of service Up to 1 hour	Loss / Interruption of service 1 to 4 hours	Loss / Interruption of service 4 to 8 hours	Loss / Interruption of service 8 hours to 2 days	Loss / Interruption of service More than 2 days

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NHS Resolution

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Environmental Impact	Minimal or no impact on the environment including contamination, not directly coming into contact with patients, staff or members of the public	Minor impact on the environment	Moderate impact on the environment	Major impact on the environment including ward closure	Catastrophic impact on the environment including multiple ward or hospital closure
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Finance including claims	No obvious / small loss < £5k	£6k - £99k	£100k to £250k	£251k to £999k	Over £1m
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory guidance	Breach of statutory legislation reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices low performance rating. Critical report	Multiple breaches in statutory duty Prosecution Complete system change required Zero performance rating Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Element of public expectation not being met	Local media coverage – long term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house) Total loss of public confidence
Quality/ Complaints	Unsatisfactory patient experience not directly related to patient care Locally resolved concern	Overall treatment or service suboptimal Justified formal complaint peripheral to patient care	Treatment or service has significantly reduced effectiveness Justified formal complaint involving lack of appropriate clinical care, short term effects	Non-compliance with national standards with significant risk to patients if unresolved Justified multiple formal complaints. Serious mismanagement of care, long term effects	Totally unacceptable level or quality of treatment/service Ombudsman Inquiry Legal Claim

Table 2 – Likelihood

	1	2	3	4	5
% Chance of recurrence of consequence in identified group	1 - 5%	6 - 25%	26 – 50%	51 – 75%	76 - 100%

Resolution

Likelihood	Consequence				
	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

*Wrong Site Surgery; Retained instrument post-operation; Wrong route administration of chemotherapy; Misplaced naso or orogastric tube not detected prior to use; In-hospital maternal death from post-partum haemorrhage after elective caesarean section; Intravenous administration of mis-selected concentrated potassium chloride

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

Resolution

Case investigator training workshop

Workshop C.6: Patient Patterned complaint
England / Secondary Care
DELEGATE VERSION

Complaint letter from patient dated 18/11/16

ADDRESS REMOVED

To St Elsewhere's Complaints Manager

I am writing to you to complain about the abhorrent behaviour of Dr Purple, which I have directly observed whilst recovering from a heart bypass on the Rainbow Ward at St Elsewhere's Trust. I can't believe that doctors are allowed to get away with behaving so badly and wanted to ensure you are aware of this.

Dr Purple is not my actual Consultant (that is Dr Green, thankfully), but I can tell that the nurses and support staff do not feel comfortable when he is around on the ward. They mutter in corners and look nervous just by his presence! I too find him creepy and pompous.

Just today Dr Purple shouted whilst on his ward round. He tends to come round early in the mornings to ensure that everything has been done to his satisfaction. Often he finds fault in some of the most trivial things – for example, if the notes aren't exactly in the place where he would expect to find them. He is often blustery and he does have a loud voice which carries right across the ward. Mrs Stripe, who is in the bed next to mine, said that there was a right ruckus today when Dr Purple thought the new male nurse had not arranged for some documents to be collected from another clinic. We had a good chat about it when I came back from the canteen. When I saw how upset the young nurse was, I asked him what I could do to help him and he said we should complain so I am.

I do hope you can do something to ensure Dr Purple is either sacked or made to be nicer to the people he works with. Mrs Stripe says he's been a lovely doctor to her but I do not appreciate the way he behaves.

Yours sincerely,

Patient Patterned

Resolution

Case investigator training workshop

Workshop C.7: Dr Orange to Dir. Med Ed - complaint
England / Secondary Care
DELEGATE VERSION

Complaint from trainee dated 19/11/2016

ADDRESS REMOVED

To the Director of Medical Education

Following our conversation by 'phone today, I am writing to record the key aspects of our discussion.

Firstly, many thanks for being so supportive and understanding following my altercation with Dr Purple this morning. It was very useful to have someone to discuss the issues with.

This morning, during our morning ward round, Dr Purple publicly humiliated me in front of my friends and colleagues and, more importantly, the patients when he announced in an aggressive and patronising tone that I was a hopeless and rubbish doctor and would never make a cardiologist. I had been doing a pacemaker insertion a few days previously which was particularly difficult, because it was only the second time I had performed this procedure. I was incredibly embarrassed.

I was particularly upset as I have been discussing my future medical career with Dr Purple and he is aware that I have struggled with cardiology at times and the fast-paced and changing nature of the work. Ideally I suspect I would prefer to leave this speciality and work, perhaps, in public health or pathology. Dr Purple has previously been very supportive in helping me identify my areas of strength and by introducing me to colleagues in other departments to discuss my options with.

At this stage, I do not wish to pursue any direct action with Dr Purple but would like this information noted in case of any future eventualities. You advised I record this formally for your files.

Please do let me know if you need any further information.

Yours sincerely,

Dr Orange

Resolution

Case investigator training workshop

Workshop C.8: Dir. Med Ed to Dr Maroon - complaint
England / Secondary Care
DELEGATE VERSION

Complaint from Director of Medical Education dated 24/12/16

ADDRESS REMOVED

To Dr Maroon

I am writing to raise my concerns about the attitude of Dr Purple, particularly with regards to his treatment of trainees which is unsupportive and patronising.

I recently spoke with you during our update meeting and flagged up my growing concerns, particularly regarding Dr Purple's attitude towards Dr Orange. You will be aware that he publicly humiliated her during a pacemaker insertion in November and I have observed during the last month that this has destroyed her confidence and she is becoming withdrawn and cynical. A number of other trainees at St Elsewhere's have commented on this and attributed her deterioration in self-esteem to the attitude of Dr Purple. I am now raising this with you formally and to request that you speak with Dr Purple to understand what is leading to his bullying attitude.

Please let me know once you have spoken with him.

Best, Professor Grey (Director of Medical Education)

Encl: Letter from Dr Orange dated 19/11/16

NHS Resolution

Case investigator training workshop

Workshop C.9: Incident form (Vascular access)
England / Secondary Care
DELEGATE VERSION

Incident notification 1235 (Vascular access was difficult to find)

St Elsewhere's Hospital NHS Trust
INCIDENT/NEAR MISS REPORTING FORM (Clinical and Non-Clinical)

DOCUMENT FACTS ONLY PLEASE WRITE CLEARLY

Amber/Red incidents **must** be reported immediately to your Line Manager **and** to the Risk Information Team on **x1234**

DOCUMENT FACT ONLY — **Details of Person Involved in the Incident**

Full Name: Mrs B Blackshaw

Address: **123, Greenbank Road, Blackheath**

Date of Birth **13/01/46** **Post Code** **HH2 5GH**

Gender: **Female** **Ethnicity:** **British** (NPSA Requirement)

Consultant (if patient): ..... **Job Title (if staff):** .....

NHS Number: 123456 .....

Staff/Patient Number: .....

Person Type :
❒ Outpatient

.....

Date of Death: .....

Incident Date	Department / Ward Reporting The Incident	Specific Location: (e.g. bathroom)
07/01/17	Cardiovascular Department	Cardiac Catheter Laboratory

Incident Time	Site where inc. Occurred	Department/Ward where inc. Occurred	Bay No: ..... Bed No: .....
11:00	Cardiac lab.	CVD	

Description of Incident
(e.g. events before, during and after)

PLEASE WRITE CLEARLY AND AVOID JARGON / ABBREVIATIONS

Please include any relevant screening tool score (e.g. Waterlow, nutritional screening, etc)

I was called to help Dr Purple in the cardiac catheter lab as a patient was haemorrhaging from the groin during a procedure. Her blood pressure was 100/60 and the registrar had already started a bag of gelofusin to increase her blood pressure. When I arrived I realised that Dr Purple had found it difficult to get arterial access as the patient was overweight and there was a lot of adipose tissue in the groin area. I controlled the bleeding and stabilised the patient and then got access easily and completed the cardiac catheterisation. Dr Purple felt he could not proceed independently but observed me complete the investigation. There were no further complications.

.....

.....

.....

.....

.....-continue overleaf-

If medication incident, please state drug involved	Correct Drug	Drug Given (If Wrong Drug)	Is this a controlled drug
	.....	.....	Yes ☐ No ☐

Did injury occur?	Description of Injury	Patient Falls Assessment Score		Pressure Sore/Ulcer Grade
Yes ☐ No ☐	.....	Pre Incident	Post Incident	
	.....	☐	☐	☐

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

NHS Resolution

If reporting a fall please tick the relevant section if the fall occurred as a result of one of the following	The floor was being cleaned at the time of fall	Due to a defect to the flooring	Due to liquid or other contamination present on the floor
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Was any member of staff absent for 3 or more days as a result of the incident?

Yes ☐ No ☐ **First Date of Absence:** ..... **Date Returned to Duty (if known):** .....

Was any medical equipment involved?

Yes ☐ No ☐

1. **Details of Equipment (include serial number if known)**
2.
3. .....
4.
5. .....

Has the equipment been removed from service?

Yes ☐ No ☐

Other Person(s) Involved/Witnesses

1. **Dr Purple** ..... **Job Title:** Consultant
Cardiologist ..... **Ext/Bleep:** .....

2. **Dr Orange** ..... **Job Title:** Cardiology
Registrar ..... **Ext/Bleep:** .....

Flexibank?

8. ☐ Yes ☐ No
9. ☐ Yes ☐ No

Support offered to staff? (please circle) Y / N	**Is the patient aware of incident?** (please circle) Y / N	**Was this a near miss?** (please circle) If 'Yes' complete 'Near Miss Score' Y / N

Please use Risk Scoring Method to score all incidents

Actual Score					**Near Miss (Potential) Score**				
Consequence Score **(C)**	2	1 **(L)** Likelihood Score	→	Risk Score **(C x L) =** 2	Consequence Score **(C)**		**(L)** Likelihood Score	→	Risk Score **(C x L) =**

Method Descriptor Used to Identify Consequence Score

Incident Form Completed By *(all of this section must be completed)*

Print Name Dr Maroon ..... **Signature** ..... **Date** 07/01/17 .....

Job Title Clinical director ..... **Ward/Dept** Cardiology ..... **Ext/Bleep** .....

Flexibank?

10. ☐ Yes ☐ No

Follow up to be taken by: – Green (Ward / Department Manager), **Yellow** (Matron / Section Head), **Orange or Red** (Lead Nurse / HS&W Team)

Please give brief details of action taken including any support given to staff: .....

No need for action as patient not harmed .....

.....

.....

Print Name: Dr Maroon ..... **Signature:** .....

Job Title: Clinical Director ..... **Ext/Bleep:** ..... **Date:** 07/01/17 .....

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

NHS Resolution

Case investigator training workshop

Workshop C.9: Incident form (Pacemaker)
England / Secondary Care
DELEGATE VERSION

Incident notification 67893 (Difficulty with pacemaker insertion)

St Elsewhere's Hospital NHS Trust
INCIDENT/NEAR MISS REPORTING FORM (Clinical and Non-Clinical)

DOCUMENT FACTS ONLY PLEASE WRITE CLEARLY

Amber/Red incidents must be reported immediately to your Line Manager and to the Risk Information Team on x1234

Details of Person Involved in the Incident

Full Name: Mr B Brown **Address:** 456, Violet Parkway Road, Blackheath **Date of Birth** 13/01/49 **Post Code** HH7 5AB **Gender:** Male **Ethnicity** British (NPSA Requirement) **Consultant (if patient):** **Job Title (if staff):**	**NHS Number:** 7600789 **Staff/Patient Number:** **Person Type :** ❒ Outpatient **Date of Death:**

Incident Date	**Department / Ward Reporting The Incident**	**Specific Location: (e.g. bathroom)**
12/01/17	Cardiovascular Department	Cardiac Catheter Laboratory

Incident Time	**Site where inc. Occurred**	**Department/Ward where inc. Occurred**	**Bay No:** / **Bed No:**
11:00	Cardiac lab	CVD	

Description of Incident (e.g. events before, during and after)

PLEASE WRITE CLEARLY AND AVOID JARGON / ABBREVIATIONS

Please include any relevant screening tool score (e.g. Waterlow, nutritional screening, etc)

I was called to help Dr Purple in the cardiac catheter lab as he was having difficulty with a pacemaker insertion. The site was very swollen and bruised when I arrived due to some bleeding. Dr Purple had had difficulty finding venous access in the left subclavicular route and had extended the incision. I decided to continue to proceed on this side and managed to cannulate the left subclavian vein easily. I proceeded with the pacemaker insertion via this route without further problems..

-continue overleaf-

If medication incident, please state drug involved	**Correct Drug**	**Drug Given (If Wrong Drug)**	**Is this a controlled drug** Yes ☐ No ☐

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

NHS Resolution

Did injury occur? Yes ☐ No ☐	Description of Injury	Patient Falls Assessment Score	Pressure Sore/Ulcer Grade ☐

If reporting a fall please tick the relevant section if the fall occurred as a result of one of the following	The floor was being cleaned at the time of fall Yes ☐ No ☐	Due to a defect to the flooring Yes ☐ No ☐	Due to liquid or other contamination present on the floor Yes ☐ No ☐

Was any member of staff absent for 3 or more days as a result of the incident?

Yes ☐ No ☐ **First Date of Absence:** ..... **Date Returned to Duty (if known):** .....

Was any medical equipment involved? Yes ☐ No ☐	**Details of Equipment (include serial number if known)**	Has the equipment been removed from service? Yes ☐ No ☐

Other Person(s) Involved/Witnesses

1. **Dr Purple** ..... **Job Title:** Consultant
Cardiologist ..... **Ext/Bleep:** .....

2. **Dr Orange** ..... **Job Title:** Cardiology
Registrar ..... **Ext/Bleep:** .....

Flexibank? Yes ☐ No ☐ Yes ☐ No ☐

Support offered to staff? (please circle) Y / N	Is the patient aware of incident? (please circle) Y / N	Was this a near miss? (please circle) If 'Yes' complete 'Near Miss Score' Y / N

Please use Risk Scoring Method to score all incidents

Actual Score	Near Miss (Potential) Score
Consequence Score **(C)** 2	Consequence Score **(C)**
(L) Likelihood Score 1	**(L)** Likelihood Score
Risk Score **(C x L) =** 2	Risk Score **(C x L) =**
Method Descriptor Used to Identify Consequence Score	

Incident Form Completed By *(all of this section must be completed)*

Print Name Dr Maroon ..... **Signature** ..... **Date** **12/01/17**

Job Title **Clinical director** ..... **Ward/Dept** **Cardiology** ..... **Ext/Bleep** .....

Flexibank? Yes ☐ No ☐

Follow up to be taken by: – Green (Ward / Department Manager), **Yellow** (Matron / Section Head), **Orange or Red** (Lead Nurse / HS&W Team)
Please give brief details of action taken including any support given to staff: .....

No need for action as patient not harmed .....

.....

.....

Print Name: Dr Maroon ..... **Signature:** .....

Job Title: Clinical Director ..... **Ext/Bleep:** ..... **Date:** .12/01/17 .....

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

Resolution

Case investigator training workshop

Workshop C.11: Dr Purple character reference
England / Secondary Care
DELEGATE VERSION

Information from Dr Purple: Letter from ex-colleague, consultant Dr Cerise, dated 23/01/17

ADDRESS REMOVED

To Dr Mauve

Following a request from Dr Purple, I am writing to provide a strong character reference for my good friend and colleague who is currently at the centre of an unfair and unjust witch hunt.

I have worked with Dr Purple for over 15 years at St Elsewhere's. During this time, he was widely regarded as an excellent colleague and an amazing clinician. I have never known him to be anything but courteous, supportive and mild-mannered. He is passionate about his work and advances in cardiology, such as CT angiography, but I found this to be enthusing and motivating.

I know Dr Purple is under a bit of pressure at the moment due to reductions in staff numbers and some difficult trainees but I know he would never lose his temper. He is finding this review into his performance difficult and I do hope you can ensure it is concluded as soon as possible.

Yours sincerely, Dr Cerise

Case investigator training workshop

Workshop D: Interview skills practice
England / Secondary Care
DELEGATE VERSION

Scenario One

Descriptors of structured interviewing	**Positive behaviour** (include specific examples wherever possible)	**Areas for development** (include specific examples wherever possible)
The CI has prepared effectively for the interview		
The CI establishes rapport		
The CI initiates and supports a free narrative account		
The CI questions effectively		
The CI closes the interview effectively		

Scenario Two

Descriptors of structured interviewing	**Positive behaviour** (include specific examples wherever possible)	**Areas for development** (include specific examples wherever possible)
The CI has prepared effectively for the interview		
The CI establishes rapport		
The CI initiates and supports a free narrative account		
The CI questions effectively		
The CI closes the interview effectively		

Case investigator training workshop

Workshop E: Interview skills practice
England / Secondary Care
DELEGATE VERSION

Observer: **Case investigator:**

Descriptors of structured interviewing	**Positive behaviour** (include specific examples wherever possible)	**Areas for development** (include specific examples wherever possible)
The CI has prepared effectively for the interview		
The CI establishes rapport		
The CI initiates and supports a free narrative account		
The CI questions effectively		
The CI closes the interview effectively		

Case investigator training workshop

Workshop E: Interview skills practice
England / Secondary Care
DELEGATE VERSION

Self-reflection form

Descriptors of structured interviewing	I will continue doing …	I'd like to stop doing …	I'd like to start doing …
The CI has prepared effectively for the interview			
The CI establishes rapport			
The CI initiates and supports a free narrative account			
The CI questions effectively			
The CI closes the interview effectively			

NHS Resolution

Case investigator training programme

Workshop F - Investigation of Dr Purple - Report Writing (Secondary Care)

This programme has been prepared by NHS Resolution (Practitioner Performance Advice)

Advise / Resolve / Learn

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

NHS Resolution

Further evidence collected during the investigation

Report
Organisation's name: St Elsewhere's Hospital
Report of a visit to the Cardiac Catheter Laboratory
Organisation's case reference number: XYZ123

Date: 01/02/2017

Background

1. As Case Investigator I undertook a visit to the Cardiac Catheter Laboratory (CCL) on 01/02/2017 to see if there was further information available in relation to the three incidents which are included in the terms of reference (ToR 1 and ToR 4) for this investigation and which occurred in the CCL. I also sought to understand the policies and procedures in place in that area, particularly in relation to how sharps were used and disposed of.
2. I was accompanied by Mrs Greenbank, Manager of the Cardiovascular Department, who was the senior manager responsible for the CCL. Mrs Greenbank's professional background is as a Cardiac Technician and she had worked clinically within the CCL prior to being appointed to her current post. She had been appointed as a Cardiac Technician in the Trust when the CCL opened, having previously trained and worked elsewhere.
3. Prior to the visit I had reviewed St Elsewhere's policy on disposing of sharps directly and had also taken advice from the Operating Theatre Manager on their Standard Operating Procedure and the equipment they had available. I had also taken advice from the Regional Cardiac Centre on what would be expected in the CCL in terms of sharps management and data collection on procedures.
4. The visit was undertaken on a morning when there were no patient procedures scheduled to minimise any disruption.

Findings

5. The area was clean but somewhat cramped. Mrs Greenbank explained that the department was now over 10 years old and the range and number of procedures carried out annually now exceeded what had originally been expected by about 50%. Areas such as the patient waiting and recovery areas were particularly noted as being small.
6. I was shown the main area, where procedures are carried out. There were a variety of sharps bins available, one of which was large and on a moveable stand

so that larger items could be dropped directly into it. All of the bins seen were in good condition, properly labelled and not overfilled.

7. I saw that there was no clear information on sharps disposal within the working area as is recommended by Health and Safety guidelines.
8. There was no Standard Operating Procedure for managing sharps in the area, such as I had found in the theatre area. Mrs Greenbank told me that since the incident she had spoken with the Theatre Manager and the Risk Manager and one had been drafted but was waiting for approval.
9. Mrs Greenbank also showed me some sharps disposal pads which she had borrowed from the Operating Theatres to try; she said these would be suitable for collecting the smaller needles used, such as the one which injured Staff Nurse Red, but would not be suitable for some of the larger sharps. Although she had them they had not yet been used as staff needed training in their use. She commented that they would also make it easier to do a proper needle count at the end of the procedure. I asked her if there was anything available for those and she said that she was waiting for some samples of sterile sharps disposal boxes which could be placed on the operating tray.
10. I asked what information was routinely collected apart from the patient data and procedure details. Mrs Greenbank showed me that all procedure times and x-ray exposure durations were recorded, as required by guidelines. She told me that the radiographers had said that Dr Purple's x-ray exposures and duration of procedures appeared to have increased lately and were often longer than those of other Consultants. Any complications during the procedure were also recorded although that depended on them being declared or agreed by the operator. Mrs Greenbank agreed to get a report prepared showing the duration of procedures and x-ray exposure times by Consultants over the last year. She would also provide some guidance they had on what was acceptable. She also agreed to see if she could identify the number and type of complications from local data and Datix.

Signed: Dr Neon
Date: 04/02/2017

I agree that this is an accurate record of Dr Neon's visit to the CCL

Signed: Mrs Greenbank
Date: 08/02/2017

Resolution

Witness statement – Dr Orange

Name of witness:	Dr Orange
Occupation:	ST3
Department:	Cardiology Department
Organisation's case reference number:	XYZ123
Statement taken by:	Dr Neon
Date of statement:	**XXX**
Present at interview:	Alison Green, HR Business Partner

Statement:

1. My name is Dr Orange. I am employed by Greater Southwest Conglomerate Hospitals NHS Trust on behalf of the Deanery. I am a ST3 and have been on rotation working in the Cardiology Department at St Elsewhere's Hospital for eight months.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and clinical practice of Dr Purple being carried out in accordance with Trust Policy HR05 'Policy for Managing Conduct and Capability Concerns in Doctors and Dentists'.

3. I have been asked about an incident that occurred on Thursday, 20 November 2016. Last November was a particularly busy time as we were a Consultant and Registrar short due I think to maternity leave and sickness absence. The whole team was very stretched and we seemed to have more patients and incidents to deal with than ever.

4. I wasn't having a good week. On Tuesday, 18 November 2016, I had been asked to insert a pacemaker. It was particularly difficult because the patient, who was 76, was quite unwell. This was only the second pacemaker insertion that I had done and I wasn't feeling particularly confident about it and I was also quite tired. All started well with the procedure but I soon struggled. Dr Purple stepped in to help but he seemed quite exasperated about it. By this I mean that he had a bit of a condescending attitude and a slightly raised voice, which made me think that he was irritated that I could not just get on and do the procedure on my own. Dr Purple then didn't ask me any questions during the rest of the morning, which is a sure sign that you are out of favour.

5. On the morning of Thursday, 20 November 2016, I had been running a little bit late for the ward round as I was helping another trainee with a difficult patient. Dr Purple is very hot on timekeeping and so was quite miffed that we were both late. Dr Purple asked me a specific question about the care of a 50 year old female patient who had been admitted that morning. I can't now remember exactly what Dr Purple's question was, but I do remember that it was a very technical question about the aftercare of a pacemaker. I had no idea what the answer was.

6. I really dislike being shown up in front of my peers and my recollection is that I didn't respond at all to Dr Purple, but just looked down at the floor. That's when it got awful. Dr Purple suddenly became aggressive, patronising and dismissive towards me. In front of everyone on the ward round, and in front of the patients, Dr Purple raised his voice and said words to the effect that I was a hopeless doctor. I have been asked whether I recall the exact words that Dr Purple used. I am afraid that after this length of time I can't remember exactly what was said but I can remember how I felt. I doubt that Dr Purple used the exact words "you are a hopeless doctor" but that was the sentiment that he intended. I suspect that this was the final straw with Dr Purple's patience as he didn't seem to be having a good week that week either and he had been snappy with everyone all week.

7. I don't like showing that I'm upset at work so I didn't really react then and there to what Dr Purple had said but I made some excuse and rushed off to the bathrooms for a short sob. I then went back to the ward round and carried on.

8. I think that this was the most demeaning and offensive incident that has ever happened to me at work. Dr Purple was just so rude and I felt publically humiliated and incredibly embarrassed. For the rest of the morning I thought about what had happened, and that afternoon I rang my Director of Medical Education, Professor Malachite, for some advice as I was really upset. Professor Malachite was really brilliant and calmed me down. Professor Malachite asked me whether I wanted to escalate the matter further but I said no. Professor Malachite did ask me to put our conversation in writing which I did.

9. I have been shown a copy of my letter to Professor Malachite dated 20 November 2016, marked as **Appx 3 – Item f**. In this letter I state:
    a. "This morning, during our morning ward round, Dr Purple publically humiliated me in front of my friends and colleagues and, more importantly, the patients when he announced in an aggressive and patronising tone that I was a hopeless and rubbish doctor and would never make a Cardiologist."

10. I have been asked whether my letter was a verbatim record of what Dr Purple said. I really can't remember and can't absolutely say for sure that that those are the exact words that Dr Purple used.

11. I have been attending counselling and careers advice at the Deanery and I now feel less personally attacked by the incident with Dr Purple. I am considering moving from hospital medicine to general practice. I have been asked whether Dr Purple ever apologised to me about this incident. Dr Purple has never spoken to me about the incident or apologised to me for his behaviour.

12. I have been asked about my working relationship with Dr Purple in general. I have a huge amount of respect for Dr Purple professionally. He is an amazing Cardiologist and I've seen him perform procedures with a huge amount of ease and grace. I couldn't imagine anyone who I'd learn more from, but my main issue with Dr Purple is that he's just so rude and old school about things. He's patronising, condescending and aggressive with most of the staff, including the trainees. I suspect that Dr Purple doesn't know how he comes across as most of the staff try to maintain a dignified face in front of him. I have been asked whether I can provide specific examples of Dr Purple's behaviour, but I can't think of any specific incidents, it is more that this is the general day to day atmosphere. Dr Purple is an absolute terror to work with. However, when I meet with Dr Purple individually, I know him to be friendly and supportive. Dr Purple has previously been very supportive in helping me to identify my areas of strength and discussing my future medical career.

This statement was drafted on my behalf by Dr Neon and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.
This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a disciplinary hearing. I understand that I may be required to attend any hearing as a witness.
Signature
Date

NHS Resolution

Witness statement

Name of witness:	Dr Maroon
Occupation:	Consultant Cardiologist/Clinical Director
Department:	Cardiology Department
Organisation's case reference number:	XYZ123
Statement taken by:	Dr Neon
Date of statement:	**XXX**
Present at interview:	Alison Green, HR Business Partner

Statement:

1. My name is Dr Maroon. I am employed by St Elsewhere NHS Trust as a Consultant Cardiologist. I have held this post for 5 years.

2. I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and clinical practice of Dr Purple being carried out in accordance with Trust Policy HR05 'Policy for Managing Conduct and Capability Concerns in Doctors and Dentists'.

3. I was appointed Clinical Director for Cardiology one year ago. I work within a team of six Cardiologists, including Dr Purple. I was previously Dr Purple's Registrar for six months. In addition to my Clinical Director role I have a full clinical load of two clinics a week, two cardiac catheter lists and three ward rounds. I applied for the job as Clinical Director as I want to learn about medical management, hopefully with a view to becoming a Medical Director one day. I have not yet had any specific training, support or development for my Clinical Director role although I had understood that this would be provided.

4. I have been asked whether, in my role as Clinical Director or as a Consultant colleague of Dr Purple, I am aware of any concerns regarding his behaviour or clinical practice.

5. In late December 2016, during my regular update meeting with Professor Malachite, Director of Medical Education, he raised with me concerns regarding Dr Purple's treatment of trainees and specifically in respect of Dr Orange. I asked Professor Malachite to put his concerns to me in writing, which he did. Attached to this statement as **Appx 3 – Item g** is a copy of Professor Malachite's letter dated 24/12/16.

6. Dr Orange now works with me and is a valued member of the team. I spoke to Dr Orange who explained that in November 2016, Dr Purple had shouted at her in front of staff on the ward saying that she was useless at pacing wires and would never make a good Cardiologist.

7. I decided to try to deal with the matter informally, in the first instance, and I had a quiet word with Dr Purple during drinks at the pub. I explained that Dr Orange

had felt publically humiliated and that it was felt that Dr Purple's comments had destroyed Dr Orange's confidence. Dr Purple apologised to me and said that he would have a word with Dr Orange and apologise to her. I do not know whether Dr Purple did speak to Dr Orange as I have not followed this up with either of them.

8. I did not document my discussions with Dr Orange or with Dr Purple. In retrospect I would have done so.

9. In my role as Clinical Director, I have been made aware by the Trust's Complaints Manager that in the last three months there have been two patient complaints alleging that Dr Purple has raised his voice on the ward. I was not present on the ward at the time of either of the alleged incidents and I had no involvement in the complaints process.

10. I have been asked about two incident report forms that I completed. The first Incident Report (Incident number 12345) relates to an incident on 07 January 2017. I completed the Incident Form on the same day. The Incident Form is attached as **Appx 3 – Item h.**

11. Incident 12345 concerned an 86 year old obese lady. I was called to assist Dr Purple in the Cardiac Catheter Laboratory as the patient was haemorrhaging from the groin during the procedure. I was called by the Radiographer as the other members of the team were all scrubbed and the Radiographer was not involved in the procedure at that time. I am not sure whether Dr Purple had asked the Radiographer to call me or whether it was another member of staff who had asked for me to be called.

12. Dr Purple was trying to access the patient's femoral artery to undertake cardiac catheterisation. When I got there Dr Purple was dabbing at the area with a swab and saying he couldn't see what he was doing because of the bleeding. Although there was blood, it appeared to me to be venous blood, not arterial. Dr Purple said he had tried a few times to find the artery but hadn't been able to. He thought it must be deeper than usual. The patient was overweight and there was a lot of adipose tissue in the groin area.

13. Dr Purple seemed not to have any idea what to do next. Dr Orange was also there and had started an IV infusion but Dr Purple kept telling her not to raise the blood pressure too much or he wouldn't be able to see. I scrubbed up, spoke to the patient and told her that I would be applying some pressure to the area for a while, and reassured her. I also asked if she felt alright (she felt a bit 'woozy') and asked Dr Orange to keep an eye on the monitors. Having stopped the bleeding by applying pressure for a short time I cleaned the area, adjusted the position of the patient's leg slightly and carried on with the procedure. I managed to

cannulate the artery on my first attempt, passed the catheter and carried out the angiography. Dr Purple stood beside me but said very little.

14. I noticed at the time that Dr Purple's left hand had a slight tremor but thought it was because he was stressed with the case.

15. A week later on 12 January 2017, I was again called by a Radiographer to assist Dr Purple in the Cardiac Catheter Laboratory. Again, I do not know whether it was Dr Purple or another member of the team who decided to call for me. This incident (Incident Number 67893) concerned a 66 year old male patient. Dr Purple was having difficulty inserting a pacemaker. Again Dr Purple appeared to be struggling to find vascular access, this time the subclavian vein. It looked like he had also had trouble dissecting the pocket for the pacemaker as the whole area was by then somewhat swollen and bruised looking. I noticed that Dr Purple had extended his original incision, which was by then quite a lot larger than usual for a pacemaker insertion.

16. Dr Purple said that he was having difficulty as the patient wouldn't keep still. I checked with the patient whether he was uncomfortable and he said it was not so much the procedure as lying on such a flat table that was making him uncomfortable. I asked the cardiac technician if she could help by putting a pillow under the patient's knees, which she did, and the patient said that it made him more comfortable, although he did twitch his feet a bit still. Once the patient was settled I was able to proceed and successfully inserted the pacemaker and sutured the wound. When I left the pacemaker had been set and was working as intended. Although the procedure overall took longer than expected I don't think the patient suffered any lasting harm although the scar will be longer than he may have been led to expect.

17. Dr Purple seemed concerned but was alright when I left the department after completing the case with him watching me. I completed an Incident Form which is attached as **Appx 3 – Item i**.

18. I have been asked if I have ever had to call for help myself and whether I have ever been called to help colleagues other than Dr Purple. As far as I remember, I have on one occasion, several months ago, asked a colleague to come and assist me and I can remember also being called to help one of the other Consultants in the early part of last year. I did not complete Incident Forms on either of these occasions. I have been asked why I completed Incident Forms for the two occasions that I was called to assist Dr Purple. Due to the fact that in the last couple of months there had been two patient complaints about Dr Purple, and the incident with Dr Orange, I was beginning to get a bit worried about Dr Purple and thought that I should make sure that things were documented.

19. I have been asked about the procedure in the Cardiac Catheter Laboratory for disposing of sharps. There are yellow sharps disposal boxes in the laboratory and I dispose of the shapes in these yellow boxes.

This statement was drafted on my behalf by (name of case investigator) and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.
This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a disciplinary hearing. I understand that I may be required to attend any hearing as a witness.
Signature
Date

Resolution

Witness statement

Name of witness:	Staff Nurse Red
Occupation:	Registered Nurse
Department:	Cardiology Department
Organisation's case reference number:	XYZ123
Statement taken by:	Dr Neon
Date of statement:	**XXX**
Present at interview:	Alison Green, HR Business Partner

Statement:

1. My name is Staff Nurse Red. I am employed by St Elsewhere NHS Trust as a Staff Nurse working in the Cardiology Department. I have held this post for 12 years.

2. I have been asked to provide this witness statement in respect if an investigation into concerns about the behaviour and clinical practice of Dr Purple being carried out in accordance with Trust Policy HR05 'Policy for Managing Conduct and Capability Concerns in Doctors and Dentists'.

3. Dr Purple was already in post when I joined the Cardiology Department. I work with Dr Purple on the ward and in the cardiac catheter laboratory. I work three days a week in the Cardiac Catheter Laboratory and two days a week on the ward.

4. I have been asked about a needle stick injury which I sustained on 14/11/16. On this day the list had overrun slightly so I was in a bit of a rush as I was late going home. I was cleaning Dr Purple's operating tray and when I was lifting the drapes I suddenly felt a sharp pain in my right middle finger. I looked down at my hand and could see through my glove that there was some blood on my finger. I stopped clearing up and asked my colleague, Nurse Aqua to take over and finish clearing but I told her to be careful. I took my glove off and went to the sink to wash my hand as I remembered having been told that you should do that as soon as possible. My finger didn't bleed for very long and I put a small plaster on it.

5. I was really angry with Dr Purple and told him what had happened. Dr Purple response was that I should be more careful in cleaning up after him in future. I felt that Dr Purple was implying that it was my own fault that I had been injured but actually I thought it was his fault because he doesn't dispose of his sharps properly. As far as I am aware, it is Trust policy that it is Dr Purple's responsibility to dispose of the needles in the yellow sharps disposal bin. Instead Dr Purple just leaves the needles on the trolley for nurses to clear up, usually putting them in the kidney dish. I assume that what happened on this occasion is that the needle had fallen out of the kidney dish and into the drapes. The needle was quite small, less than an inch long, with a short length of suture material attached and I didn't see it when I lifted the kidney dish and drapes.

6. There are yellow sharps disposal boxes in the cardiac catheter laboratory and all of the other clinicians use these to dispose of used needles. Dr Purple is the only one who leaves needles on the treatment trolley.

7. I completed an Incident Form on the same day **[Appx 3 – Item d]**. On the Incident Form I said "This has happened twice before BUT this is the first time I have had an injury". I have been asked to explain what I meant by this. The first episode occurred about four months ago and the second incident happened about two months ago. On both occasions, when I was clearing away the treatment trolley I noticed that there was a needle in the drapes and I had to remove it and dispose of it. Thankfully, on these two previous occasions I saw the needles and so was able to avoid an injury.

8. On both of these previous occasions I told Dr Purple that he should not leave the needles on the treatment trolley but he ignored me. I also reported the incidents to my line manager, Mrs Greenbank but as far as I am aware nothing was done about it. I did not complete Incident Forms for the two previous occasions but I completed the form on [date] because I had been injured this time.

9. After the incident on 14/11/16 Mrs Greenbank sent me to A&E for review. Although the physical injury was only very small, the injury has had a massive impact on me. I am particularly worried as I think that the patient may have previously been an intravenous drug user. I have been asked why I didn't include the patient's details on the Incident Form **[Appx 3 – Item d]** so that this could be followed up. To be honest, I was so worried and in a bit of a panic that I just wanted to get out of the Cardiac Catheter Laboratory and get to A&E as soon as possible. I do not know for sure whether the patient had been an intravenous drug user but I thought that I recognised him from previous admissions and that is also what some of my nursing colleagues had said. However, there was nothing in the notes or on the list of procedures to indicate that this patient was a particular risk.

10. I am still waiting for the results of tests to see if I have caught anything from the needle. Every time I go for a blood test it makes me feel so worried and anxious that I have to have a day or two off work sick afterwards. At the moment I am not scrubbing up to help with procedures because of the potential risk of me infecting someone. I am thinking of asking to be transferred to ward duties only or even to another department. I feel that if my concerns had been acted upon on the previous two occasions, this injury would never have happened. I think that if it had been a nurse who had left sharps lying around then they would have been suspended and the same should happen to Dr Purple.

11. From talking to colleagues who work elsewhere in the Trust I have found out that other areas, such as the operating theatres, have other equipment to safely

collect and dispose of small sharps. I don't know why the Cardiac Catheter Laboratory isn't provided with the same equipment as the other departments. I hold the Cardiology Department and ultimately the Trust management to blame for this.

12. I have been asked whether I have any concerns regarding Dr Purple when working on the ward. On two occasions Dr Purple forgot that he had arranged to see patient's relatives and I had to phone him and ask him to return to the ward. He was extremely rude to me on the phone, shouting in an aggressive tone that it was my job to sort it out and to deal with the relatives as he was now in another hospital with patients. I can't recall specific dates but these two occasions were both within the last three months.

13. I have seen Dr Purple get angry and he is often short-tempered with nurses when he thinks they are not fully aware of the patient's condition. I have also seen Dr Purple giving trainee doctors a hard time, saying, in front of me and other nurses, that trainee doctors have it easy nowadays as when he was their age he did a 1 in 3 on call. Dr Purple said that's why he is a good Cardiologist and the current trainees won't be up to much.

14. I have been asked whether I can recall any specific incidents regarding Dr Purple's behaviour towards other members of staff. I am afraid that I cannot recall specific dates or incidents. I have never formally reported any incidents regarding Dr Purple's behaviour or kept any diary or log of such incidents. I just know that Dr Purple shouts a lot, whatever area he is working in.

15. I have been asked whether I was present during a ward round on 19/11/16 with Dr Orange and Dr Purple. I can't recall this ward round and think that I may have been at Occupational Health at the time.

This statement was drafted on my behalf by Dr Neon and I have confirmed its accuracy having seen it in draft and having been given an opportunity to make corrections or additions.
This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a disciplinary hearing. I understand that I may be required to attend any hearing as a witness.
Signature
Date

NHS Resolution

Witness statement

Name of witness:	Dr Purple
Occupation:	Consultant Cardiologist
Department:	Cardiology Department
Organisation's case reference number:	XYZ123
Statement taken by:	Dr Neon
Date of statement:	**XXX**
Present at interview:	Alison Green, HR Business Partner

Statement:

1. I am Dr Purple, a Consultant Cardiologist employed by St Elsewhere NHS Trust.

2. I have been interviewed by Dr Neon and provide this statement in respect of an investigation into concerns about my behaviour and clinical practice being carried out in accordance with Trust Policy HR05 'Policy for Managing Conduct and Capability Concerns in Doctors and Dentists'.

3. I have been in post for 28 years. As such I have seen many changes in the Cardiology Department and have seen several Clinical Directors come and go, with varying degrees of success. I know the current Clinical Director, Dr Maroon, from when he was my Registrar. In the past I considered applying for the Clinical Director role myself but I was discouraged from applying by others.

4. I have a full clinical workload and a thriving private practice. I have devoted my career to doing what is best for my patients. It was me that campaigned to get the cardiac Catheter Laboratory set up so that patients didn't have to travel so far and be put at risk when they needed urgent procedures; I performed the first procedure in the lab. I have also previously been the Chair of the Regional Cardiovascular and Stroke network. As a very experienced Consultant Cardiologist I feel that I am in the best position to know what is best for patients and I dedicate myself to providing front-line services rather than becoming embroiled in management. As an example I have strongly resisted any merging with other local hospitals to provide a 24 hour service as I think the travel would put patients at risk. I always put my patients first.

5. I have been asked about an incident that occurred on 14 November 2016 when Staff Nurse Red sustained a needle stick injury, and about my practice for disposing of sharps. My usual practice is to put the sharps in the kidney dish. The nurses know this is where they are because I have told them so. I don't see the point of putting the sharps in the yellow disposal bin myself because the nurse knows where I put them.

6. I have been asked whether the nurses have ever asked me to use the yellow sharps disposal bin. I can recall the nurses saying this but I really don't see the

point and I have told the nurses on a number of occasions to be careful when clearing up or moving things.

7. When I am doing a procedure I want to keep concentrating on what I am doing, not to keep looking round to find a bin or the kidney bowl and I certainly don't want to be distracted all the time by the nurse going on about rules, regulations and procedures. I think it was unfortunate that Staff Nurse Red had a needle stick injury but I had told her to be careful on several occasions before.

8. A copy of St Elsewhere's 'Policy on Disposing of Sharps Directly' dated July 2016 has been shown to me marked as **Appx 3 – Item k.** I have been asked whether I am familiar with this Policy. In a large organisation such as this, there are hundreds of different policies and procedures and these are always being updated or new ones introduced. As a busy clinician, I cannot be expected to be familiar with the details of all of these various policies. I have been asked whether I have attended any training sessions in respect of the Policy on Disposing of Sharps Directly. I cannot recollect attending any such training.

9. I have been asked about a patient complaint regarding an allegation that I was shouting whilst on the ward on 19 November 2016. A copy of the patient complaint letter has been shown to me marked as **Appx 3 – Item e**.

10. I have no recollection of any such incident. I do have quite a loud voice but I most certainly do not shout. I do have very high standards because I want the best for my patients, so if I find that nurses or junior doctors are not doing things correctly, I will tell them so.

11. I have been shown a copy of St Elsewhere's Policy and Protocol for Dignity at Work and the Management of Harassment and Bullying HR01 – **Appx 3 – Item c.** I cannot recall ever being provided with any training about this policy.

12. I have been asked about an incident on 20 November 2016 involving a trainee, Dr Orange. I have also been shown a copy of a letter from Dr Orange to the Director of Medical Education dated 20 November 2016 (**Appx 3 – Item f**). Dr Maroon brought this matter to my attention over drinks one night. Before Dr Maroon mentioned it to me, I had no idea that Dr Orange may have taken offence at something that I said.

13. I can recall giving Dr Orange feedback about her lack of skills in inserting pacemakers and her lack of knowledge about their care. It's my job to give feedback to trainees, they need to have feedback or they will never improve. I don't think that Dr Orange should have felt embarrassed or humiliated by receiving feedback. The trouble with trainees nowadays is that the training they

receive is substandard which means that the trainees are never going to be as good as when I was training.

14. I have been asked whether I apologised to Dr Orange. Dr Orange no longer works with me, she works with Dr Maroon, so I only ever see her in passing and have not had the opportunity to speak to her about this incident.

15. I have been shown two incident forms completed by Dr Maroon dated 07 January 2017 and 12 January 2017 (**Appx's 3 – Item h and Item i).** I have also had the opportunity to review the case notes for each procedure.

16. It is not unusual to have difficulty with finding arteries or veins, it all depends on the patient's anatomy and it is variable. Both of these patients were rather difficult: one was obese which always makes it difficult and the second patient wouldn't lie still. Some of my junior colleagues use ultrasound to locate vessels but I don't think that should be necessary. I learnt to do it by knowing the anatomy and the landmarks and I have done thousands of procedures successfully by that method.

17. I was not feeling myself on those two occasions and I admit that I was grateful for help from Dr Maroon. However, it is not unusual for colleagues to help each other with procedures and the younger ones do it all the time. Given that I am the most experienced Consultant in the Department, I am confident that I seek help considerably less frequently than the others and in fact I cannot recall having to ask for help in recent memory. I do however get called to help other colleagues quite often, especially with these trainees these days.

18. In respect of the incident on 07 January 2017 concerning arterial access, I asked the Radiographer to call Dr Maroon and I believe that in the situation this was the correct and proper thing to do. I am not sure how Dr Maroon came to be called on 12 January 2017 and it may be that Dr Maroon happened to pop in to the laboratory for some reason just when I needed help and so I asked him to come and have a look.

19. I really do not understand why Dr Maroon completed Incident Reports on these two occasions and I do not believe that it was necessary for him to do so. Both procedures were completed satisfactorily and there was no harm to the patients.

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

This statement is true to the best of my knowledge. I understand that my signed statement may be used in the event of a disciplinary hearing. I understand that I may be required to attend any hearing as a witness.

Signature
Date

Resolution

Report template
Strictly confidential

Organisation's name: St Elsewhere

Report of investigation into concerns raised in relation to Dr Purple

Organisation's case reference number: XYZ123

Date:

NHS Resolution

Contents

Introduction

Give a brief introduction to the investigation, its relationship with any investigations by other bodies and the procedures and regulations governing the present investigation.
You should include references to organisational polices being followed.

Background

Include relevant career information about Dr Purple and work with the organisation.
Give reasons for the investigation in more detail.

The investigation

State the specific allegations for investigation. Describe the team carrying out the investigation (with names, job titles and qualifications), the terms of reference as set initially plus any subsequent amendments.

The matters to be investigated are:

TOR1. the circumstances around the incident where a member of staff sustained a needle stick injury in the cardiac catheter laboratory on 14/11/16 (incident no 1462)

TOR2. the circumstances related to the complaints from a patient about shouting at staff on wards on 18/11/16

TOR3. the circumstances related to the complaint from the trainee about Dr Purple stating she will never make a cardiologist

TOR4. the circumstances related to the two incidents in the catheter laboratory:

a. patient no 12345 where venous access was difficult to find
b. patient no 67893 where there was difficulty with a pacemaker insertion.

Methods

This should include for example:

- review of documentary evidence, including patient records
- interviews with specified patients and/or colleagues.

If any expert witnesses were used their expert credentials should be reported. There should be a list of all people interviewed and the capacity in which they were involved in the investigation.

State what has happened in the investigation process. Explain any delays in carrying out the investigation and the reasons for this. Set this out in chronological order and with supporting evidence identified.

Summary and analysis of evidence

Set out in detail all of the relevant evidence. Under each ToR set out the chronology of the incident (where possible) and link to the supporting evidence. Where the evidence includes the opinion of experts on a standard of care, the required standards of care should be quoted and may be added as an Appx.

The summary should draw attention to any conflicts of evidence

NHS Resolution

Appendices

These should be numbered and referred to in the text of the report.

These include evidence collected as well as other items for example:

- clinical incident reports
- complaints
- witness statements
- expert witness reviews/opinions
- photographs (must be labelled)
- national or organisational standards relating to care
- codes of conduct e.g. Duties of a doctor (GMC).

Name of case investigator or investigating team:

Signature:

Date:

NHS Resolution

Case investigator training workshop

Workshop G: Responding to potential challenges
England / Secondary Care
DELEGATE VERSION

Part 1: Challenges for the case investigator

Dr Purple objects to a previous Clinical Director in Cardiology being appointed the case investigator – he says that they have prior knowledge of his situation and the concerns because they were the previous Clinical Director. This means that they must be biased against him because they were aware of the gossip about his bad behaviour, which form part of the Terms of Reference.

What are your views on this challenge and how would you reply to it?

In the course of the full investigation, you receive an anonymous note (passed on via the Case Manager) alleging bullying by Dr Purple against the "support staff". The note states that people will give evidence if they are granted anonymity

What would you do?

You try on several occasions to meet with Dr Purple but you are told he is unavailable – you have written to him formally and he responds in writing to notify you he is unavailable. If you continue to seek his involvement at this stage, the delay will cause you to take longer than the originally planned in which you were asked to complete the investigation. You tell him that you are prepared to proceed in any event and he states he is unwell.

What would you do now?

Dr Purple states he would like to have his lawyer present with him when you interview him and that he would like the discussion to be tape-recorded. He states he has a human right to both of these. Before the meeting, he also wants to see the full statements of everyone who has been interviewed and all the evidence collected to date. He wants full copies of any notes you have made during the investigatory process and any emails you have sent to anyone at the Trust (including the CM) concerning the investigation.

How would you respond to Dr Purple's requests?

Part 2: Challenges during the investigation process

It is eight weeks since the start of the process and you have not been able to complete the investigation. Dr Purple's lawyers write to the Trust stating the investigation process is fundamentally flawed because:

- The notes and papers you have provided to them reveal you are biased against Dr Purple – you should not be allowed to continue and a new Case Investigator should be appointed to start a fresh investigation.
- The evidence from the interview you carried out with Dr Purple was unsafe as you badgered him into providing answers when he was unwell and you should have allowed his solicitor to be present.
- The time the investigation is taking is inordinately long.

The Trust needs to respond and seeks legal advice.

What documentation will you need to provide to the Trust's solicitors?

The Trust's solicitors would like to take a statement from you on the points of challenge.

1. **What information do you think you will need to give them?**

2. **Is there anyone else you think the solicitors will need to speak to?**

Dr Purple's lawyers also allege that the investigation is flawed because Dr Purple has not been allowed access to information to undertake his own audit into needle stick injuries throughout the department in the last three years, to demonstrate he is "*no different from anyone else*".

How would you respond?

As part of your investigation and documentary evidence you have received many character references from current and past colleagues of Dr Purple.

The Case Manager receives robust evidence to demonstrate that Dr Purple has been coercing some staff into providing some of these character references.

How does this affect your investigation?

Part 3: Challenges after the process

The panel issues a final warning for not following the Trust's sharps disposal policy which Dr Purple appeals. His appeal is unsuccessful.

Within the next four months a further incident where Dr Purple fails to follow the sharp's policy occurs.

At a disciplinary hearing, Dr Purple is found guilty of gross misconduct. He is dismissed from St Elsewhere's Hospital NHS Trust.

Two months after his dismissal Dr Purple brings a claim to the Employment Tribunal. Dr Purple claims unfair dismissal, on the basis that the Trust failed to follow the correct procedure in dismissing him and, in particular, that the Case Investigator was biased (as raised previously), and that the sanction of dismissal was disproportionate in all of the circumstances.

The Trust's solicitors ask you for documents relating to the investigation.

Should you send them any of the following?:

- Personal emails on your home computer in which you have joked with a colleague about how difficult Dr Purple is;
- Post it notes with doodles you drew while you were interviewing Dr Purple;
- Unanonymised notes of discussions with witnesses who have asked for anonymity;
- Old drafts of the investigatory report. You are concerned that the drafts are quite different because you started producing them at different times during the investigation.
- Your personal diary which has entries of the interviews you carried out.
- A thank you card received from ex-colleagues of Dr Purple, received after he has been dismissed?

NHS Resolution

Personal and Organisational Action Planning Form

Name:	

What do I/we want to learn/ /improve/share with others?	What will I/we do to achieve this?	What resources or support will I/we need?	What will the success criteria be?	What are the target dates for review?

Issued by the Urology Services Inquiry on 5 October 2022. Annotated by the Urology Services Inquiry.

Resolution

What do I/we want to learn/ /improve/share with others?	What will I/we do to achieve this?	What resources or support will I/we need?	What will the success criteria be?	What are the target dates for review?

National Clinical Assessment Service

Case investigator training workshop

For Southern Health and Social Care Trust

Tuesday 07 – Wednesday 08 March 2017

09:15-16:45 (Day 1) and 09:00-16:00 (Day 2)

Seagoe Parish Centre, 46 Seagoe Road, Portadown, Co. Armagh, BT63 5HW

EVALUATION REPORT

This report brings together objectives and impact of the two day NCAS Case investigator training workshop for *Southern Health and Social Care Trust* delivered on Tuesday 07 – Wednesday 08 March 2017, as well as suggestions for follow-up.

Next steps

1. Consider actions in this report from respondents relating to what support delegates need to fulfil their role as Case investigator (CI) and what the Trust needs to do to ensure effective management of investigations (see page 5).
2. Circulate this report to those with an interest in the outcomes of the workshop, gathering in comments and suggestions for follow-up and sharing with NCAS if relevant.

Summary

The Trust identified a need to provide formal training for their experienced clinicians who undertake investigations as well as expand their cohort of trained investigators.

The workshop was delivered by Colin Fitzpatrick, NCAS Senior Adviser (Northern Ireland), who is also the NCAS link adviser for the Trust, and Grainne Lynn, NCAS Adviser. Both advisers regularly provide advice on the management of concerns about performance of practitioners as part of their role at NCAS and have an in-depth and extensive knowledge of the national frameworks.

Delegates were supplied with a pre-reading document in advance and following the workshop, were given an online link of resources and an evaluation form. Certificates of attendance were supplied noting they counted as 12 hours towards their CPD.

The majority of respondents had little experience prior to attending the training, but were fairly confident after the training to now act as a case investigator.

The workshop seemed to be well received with delegates well engaged and interactive throughout. The overall response is very positive showing delegates appreciated the training and found it very useful.

Respondents noted increased knowledge and understanding in particular around the role of case investigator, the purpose and importance of terms of reference, having a structured approach, application of MHPS framework as well as the systems and processes of case investigation. Respondents particularly enjoyed the role play and case study sessions as they were interactive and allowed for queries to be raised and answered.

The workshop received excellent scores with all workshop sessions rated above 4.3 out of 5, and 4.7 for overall content and standard (where 1 is poor and 5 is excellent).

Evaluation feedback from respondents

Total attended	20
Total responded	14
Return rate	70%

Experience before this training as a case investigator:

Experience	% of respondents
None	14%
A little	64%
Lots	22%

Confidence after this training to act as a case investigator:

Level of confidence	% of respondents
Not at all	7%
Partially	14%
Fairly	72%
Very	7%

Summary of where the workshop's content increased understanding or developed skills can be summarised by the following comments from respondents:

- Procedure, defining terms of reference (ToR)
- Planning, preparation and structure of case management
- Being prepared for legal challenge and understanding the medical aspects
- The application of the MHPS process and the importance of well worded ToR for investigation and adherence to this
- Awareness of structured approach and use of guidelines. Clarity regarding salient issues and more confidence regarding structured interviewing
- More clear regarding role boundaries of investigator and more confidence regarding compiling witness statements and final reports
- Setting tight ToRs, planning ahead, considering questions and potential answers and where to get help
- I feel this has helped me develop my skills in fact finding and sticking to reporting on the facts
- The course was very useful in helping to focus your mind on the role of the case investigator (CI) and the role of the case manager (CM)
- Advice on and importance of ToRs, preparation and documentation has all been very useful
- Slightly better - More aware of HR aspects.

Summary of ways the workshop's content has influenced future actions can be summarised by the following comments from respondents:

- Much better understanding of process, investigator role and responsibilities and structured approach
- Excellent advice regarding achieving in central location and practical tips about cataloguing evidence
- It promotes teamwork with HR and NCAS
- I will be a lot more careful about not getting side tracked from ToR
- About to start an investigation so I will be much more careful to ensure that we have ToR right, are speaking to the right people and clearer about roles of CM and CI
- Ensure lots of effective planning/preparation before meeting any practitioners or witnesses
- I found working through case scenarios very helpful
- I will avoid giving opinion and stick to the facts
- After the course, I will be using the ToR to be clear about the scope of the investigation for the CI and focus the investigation report around the ToRs

- From completing this training, I will now ensure future investigations are undertaken within the scope of a well-defined ToR. I am also clear on the methods which should be employed when issues arise that are currently out-with the scope of the agreed ToR. Overall the course has increased my understanding of how to ensure a fair and thorough process is followed that will allow us to better defend any legal challenge.

Summary of the most helpful/useful sessions can be summarised by the following comments from respondents: *(See table below for quantative scores of sessions)*

- Writing the ToR and report
- They were all very useful but the role play help consolidate concepts learned on the first day
- I found the session on starting the investigation and ensuring it is on the right track at the outset most helpful as this has caused me some difficulties in the past
- All excellent, but maybe session on distilling out clear ToR?
- Thought all of it was excellent and well delivered. Right balance of imparting info and use of scenarios to practice
- I particularly enjoyed the role play sessions
- The practical and interactive sessions were very useful although I found all sessions to be useful. The small group enabled plenty of discussion and enabled questions to be raised and answered which again was very useful as we learnt from each other
- Working through draft examples
- All fairly similar.

Summary of the least helpful/useful sessions can be summarised by the following comments from respondents: *(See table below for quantative scores of sessions)*

- Themed data
- None, all were excellent
- All were very useful and relevant - I wouldn't want any to be replaced
- All done at a good pace, presenters good and clear and easy to listen to. They have a wealth of knowledge and very measured in their approach to this process which I hope to emulate
- The report writing section simply because this is the area I was most confident in based on my experience.
- One day would suffice

Delegates were asked if there were any other aspects that they had hoped to learn that was not covered, respondents advised:

- I think I need to do one that focuses on case manager role now
- None, not aware of any.

Summary of average evaluation ratings:
(averages out of 5.0, where 5 = excellent and 1 = poor)

Administrative scores	
Administrative process (i.e. delegate pack, training materials, pre-event administration and administration at the event)	4.7
Venue (i.e. workshop room, hotel accommodation, refreshments)	4.3
Workshop	
Pre-reading	4.1
Welcome, introductions, overview of the workshop and chairing throughout	4.8
Day 1 sessions	
Dealing with concerns about a doctor's practice	4.6
Workshop A: Dealing with concerns about a doctor's practice	4.5
Investigation roles and responsibilities	4.6
Starting the investigation	4.6
Workshop B: Critiquing terms of reference and responding to a case manager's request	4.6
Gathering evidence	4.5
Workshop C: Review of documentary evidence (Dr Purple)	4.6
Workshop D: Interviewing witnesses (trainer-led role play)	4.6
Day 2 sessions	
Workshop E: Interviewing witnesses (delegate-led role play)	4.6
Report writing	4.6
Workshop F: Report writing (Dr Purple)	4.6
Supporting the practitioner	4.3
What happens next?	4.3
Responding to legal challenges	4.4
Workshop G: Responding to legal challenges	4.4
Support for case investigators	4.5
Review of learning	4.3
Aspects of the workshop overall	
Overall content and standard of the workshop	**4.7**
Overall length of the workshop	4.4
Overall standard of training at the workshop	4.6
Overall balance of plenary and group work	4.4
Effectiveness for continuing professional development	4.6
Time for networking	4.5

Delegates were asked what support they would like to help fulfil their role of case investigator, respondents advised:

- Resource allocation including appropriate time with in job plan
- Good links with HR - I am confident same already exist and colleagues will welcome development
- I will use the website and contact NCAS for advice. I have previous experience of this and found it very helpful
- Internal support from other experienced CIs
- Supportive network time to meet regularly
- We get excellent support in this Trust from HR. Though sometimes feel DLS are bit inflexible and strict
- More support form HR and peer support
- One day course would be enough - perhaps with annual online update.

Delegates were asked what support their organisation now requires in order to manage investigations effectively, respondents advised:

- Ongoing training and peer support networking
- Time for medical staff to complete interviews and analysis without interruption
- I think networking with each other will benefit all
- Need to get a team of CI/CM for peer support
- Access to NCAS advice as appropriate
- Time/support network and learning events from live cases
- Build up a network of investigators to provide peer support and allow expertise/practice - we don't do enough to retain skills (not that we want more)
- More staff in general to allow freeing investigators from clinical workload.

Delegates were asked if they had any other comments, respondents noted:

- Cleansed verbatim data
- Extremely useful for the Trust to have a cohort of trained investigators
- One of the best courses I have been on in years!
- Sincere thank you to training team
- Excellent course - well worth the time away from clinical work
- Thoroughly enjoyable course - highly recommended!!
- Colin and Grainne were very knowledgeable and assisted greatly with queries I had of the MHPS process.

Kiu Nghiem
Programme Executive
May 2017