- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
  (a) delivery of safe, high quality and effective person-centred care
  (b) secures activity and performance
  (c) maintains ongoing financial viability
  (d) is aligned to corporate goals.

  The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key quality and performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options
- To provide quarterly updates on the progress of aspects of professional and social care governance
- Perform any other duties that are consistent with the post

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.

- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

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

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

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

8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

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2. Hold a medical qualification, GMC registration with License to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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Please note that interviews for this post will be held week commencing 3rd May 2021 (subject to change).

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director - Older Peoples Services (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; governance; quality improvement; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management, quality and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DivMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- To lead on service improvements of older peoples services including stroke services to strengthen continuity of care between primary and secondary care services.
- To lead on the development, oversight and clinical management of specialist acute elderly care services

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.

- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
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- To model the HSC values.
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Appraisal and Revalidation

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Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
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  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

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

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8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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Please note that interviews for this post will be held week commencing 3rd May 2021 (subject to change).

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Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director – Surgery and Elective Care (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

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Specific Divisional Responsibilities

- On behalf of the Medical Director represent the Trust in regional service development discussions including the development of regionalized surgical services
- Represent the Trust on the Surgical Regional Priority Operational Group

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
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SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

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Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director - Emergency Medicine and Unscheduled Care (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; governance; quality improvement; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management, quality and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DivMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- To lead on the implementation and professional and clinical management of Trust enhanced Emergency and Urgent Care services including Direct Assessment Units, Acute Medical Unit, Ambulatory Units and Urgent Care Centres
- To work with DivMD, DMD and AMD colleagues to ensure that clinical pathways across urgent care, primary care and secondary care are developed, maintained and monitored to maximise patient safety at all stages of the patient journey.
- On behalf of the Trust Medical Director lead on relevant medical clinical and professional tasks relating to the Trust No More Silos project

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop

high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.

- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:

  (a) delivery of safe, high quality and effective person-centred care

  (b) secures activity and performance

  (c) maintains ongoing financial viability

  (d) is aligned to corporate goals.

  The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key quality and performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options
- To provide quarterly updates on the progress of aspects of professional and social care governance
- Perform any other duties that are consistent with the post

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed

In conjunction with the Medical Director's Office to be involved in the oversight of

Revalidation and Appraisal processes

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

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

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

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

8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

***ESSENTIAL CRITERIA** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with License to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate

through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow him to further discuss the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal information redacted by the USI.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/

Please note that interviews for this post will be held week commencing 3rd May 2021 (subject to change).

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

Managing Concerns about Agency Locum Doctors

Guidance for Clinical Managers

Zoe Parks: Head of Medical HR

Guidance Agreed 2020/21

INTRODUCTION

The Trust is committed to providing an excellent service to all patients and clients. The Trust recognises the difficulties faced by managers trying to cover temporary staff shortages whilst meeting the need to balance the provision of ongoing high quality services. Locum Doctors can offer a great deal of flexibility to the Trust in fulfilling urgent, short term needs for staffing contributing to patient care and patient safety. For the purposes of this Guidance – a "locum doctor" is a doctor who is supplied to the Trust either by a known contracted agency or via an off framework agency Link To Agency Protocols on Sharepoint . These doctors are not "employed" by the Southern Trust - the significance of this, is that the Trust is not the doctor's designated body and their Responsible Officer is not the Trust Medical Director.

Please contact Medical HR team if you are unsure if a doctor is an employee of the Trust or an Agency locum. Please remember HSC E Locum doctors are distinct from Agency Locum Doctors as they may be engaged under a Trust bank contract and as such may need managed in line with all employees. Rotational doctors may be an employee of NIMDTA Single Employer and we must ensure the Postgraduate Dean is advised of all concerns. Please seek early advice from the Medical HR department for assistance.

PURPOSE

The purpose of this protocol is to provide guidance on managing concerns about locum doctors who are engaged **via a contracted/off framework agency**. This protocol follows some of the key **principles** as those set out in Maintaining High Professional Standards (DHSSPS 2005) (MHPS) – the guidance for managing concerns about employed doctors. (However MHPS does not apply to non-employees).

WHAT ARE MY RESPONSIBILITIES WHEN ENGAGING LOCUM DOCTORS?

When the Trust engages a locum doctor through an agency, the supervising Consultant/manager must:

- Ensure doctors are booked in line with Trust protocols and via the Southern Trust internal medical locum team as this will ensure all the necessary pre-employment checks are completed prior to engagement.

- Ensure someone is given responsibility for re-checking a locum doctors Identity check (ID) on their first day of duty/shift

- Providing suitable departmental specialty Induction to the doctor to enable them to carry out the work that they are engaged to do within your specialty – which must include access to guidance on appropriate local clinical pathways/protocols, and the process for escalating concerns.

- If a locum doctor is engaged for a longer term (e.g. over 3 months), supporting the doctor's appraisal preparation and ensuring they are able to attend the relevant governance forums such as M&M/MDT meetings etc. Consider if it would be useful to allocate a mentor/buddy to longer term locum doctors where practical and feasible.

WHEN CONCERNS ARISE?

Definition of "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)

Performance, health or conduct concerns can come to light in many ways, including

- Concerns expressed by other HSC staff
- Review of performance, conduct, behaviour
- Monitoring of data on clinical performance and quality of care
- Clinical governance, clinical audit and other quality improvement activities
- Complaints Data about care by patients or relatives
- Information from regulatory bodies
- Litigation following allegations of negligence
- Information from police or coroner
- Court judgements
- Following the report of one or more critical incidents or near misses

WHAT CONSTITUTES A CONERN?

The majority of doctors provide a high standard of patient care. The principles and values which underpin medical professionalism and the behaviour required of a doctor are described in Good Medical Practice. As medicine and technologies evolve, doctors need to enhance their skills and keep up to date, in order to remain fit to practice. Doctors are supported in the process of continuing professional development (CPD), which is facilitated through annual appraisal. CPD is enhanced by local self-directed learning, team based discussions and clinical governance processes led by the Trust. This can therefore be more problematic for locum doctors in some scenarios.

Where a doctors' standard of care falls below that defined within Good Medical Practice, CPD measures alone may not be sufficient to address the problem. A concern about a doctors practice can be said to have arisen where the behaviour of the doctor causes, or has the potential to cause, harm to a patient or other member of the public, 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. While minor concerns may be addressed through normal counselling and continuing professional development, this guidance is primarily concerned with responding to those instances where normal CPD processes are not sufficient or not feasible, due to the duration of the Locum engagement, to address the concern.

The spectrum of problems is wide and ranges from workplace coping difficulties including burnout, stressful work environments, performance issues, minor, aberrations of behaviour through to persistent unprofessional behaviours or even acts of gross criminality. Effective and fair management of locum doctors requires an objective assessment of the circumstances. It is important to involve an experienced colleague (usually Clinical Director /Associate Medical Director) early to assist in identifying and exploring underlying factors and to help set clear goals for improvement where feasible and possible. Remember: early and proportionate intervention may prevent problems becoming intractable and importantly prevent problems moving within the NHS locum system. Early intervention is essential if adverse consequences are to be avoided for patients, the doctor concerned and his/her colleagues.

There are varying ways to assess the level of a concern. At times it will be appropriate to rely on professional judgement. It is also important to regularly review Complaints data to identify patterns of behaviours/themes at a system wide level. This will be useful in not only responding to system wide about issues/events that have already happened, but also to be able to identify emerging patterns and act swiftly to prevent further issues/incidences. However use of a risk framework can also be helpful in improving consistency of response and management of concerns. Sample diagnostic tools and risk-assessment matrix is provided in the **Appendix** as a guide.

SUMMARY OF KEY ACTIONS THAT SHOULD BE TAKEN BY CLINICAL SUPERVISOR:
You must ensure that there is a system in place so if concerns about the doctor arise – you are made aware. There should be a method to ensure everyone within your specialty/department is aware how they can raise concerns and/or where to get additional advice or support. (See appendix for further details)

When a concern is raised - You must manage these concerns as set out below.

1. Consider the risk to patient safety – whilst exclusion from undertaking a locum shift may be unavoidable, it doesn't have to be the sole or first approach to ensuring patient safety. Alternative ways to manage risk until you can properly establish the facts could include; arranging supervision, restricting the doctors practice, rearranging out of hours cover. (If exclusion/restriction is being considered, you must advise the Trust Medical Director).

2. Clarify what has happened and establish the facts around the problem or concern. Seek advice from the Medical Director (or Associate Medical Director) and/or Head of Medical HR where necessary and undertake a **screening of the concern** to establish the immediate facts surrounding the complaint. This can include quickly gathering any documentary records such as timesheets/written statements. Document what has happened. Keep records of patient details involved and other witnesses at the time.

3. Inform the doctor about the concern. The doctor should normally be informed immediately about the concern that has been raised (unless fraud or other criminal activity is suspected). An initial meeting and/or discussion will provide the opportunity for the doctor to hear the concerns and respond. Check if the doctor understands how to avoid

repeating the error. This initial discussion should help determine what, if any, action needs to be taken. Locum doctors are obliged to engage with processes responding to concerns.

4. You should ensure there is early communication and discussion with the doctor aimed at improving their performance or conduct, as this may be sufficient to resolve the issue and identify early interventions to facilitate a resolution. The doctor's early response can be helpful in deciding whether further action is required. You should advise the locum doctor to seek additional support from their trade union/defence organisation. In situations where a doctor's ill health may be a significant contributory factor to their conduct or performance, then early contact with their Employer (the Locum Agency) should be sought to determine if they have access to additional health support. You can contact the Locum Medical Office within the Southern Trust to seek this advice on your behalf as necessary.

5. If concerns remain, you must gather enough information to determine if the matter needs to be escalated to the Southern Trust Medical Director so that appropriate RO notification can occur and also to determine if the locum engagement can continue. As soon as it is clear there is an established concern, the clinical supervisor must notify the Trust's Medical Director. Contact with the locum doctors RO and their locum agency will be via the Southern Trust Medical Director Office. You must forward all the details of your concern using established or email systems, along-with the findings of your screening of the concern. The Locum Agency is the employer and will have their own policies and procedures for investigating concerns for their doctors.

6. Advice can be sought from the Clinical Director, Associate Medical Director or Medical Director at any stage when determining the seriousness of the concern. You can refer to the risk-assessment matrix in the Appendix section, to help you assess the seriousness of the concern. In general the following examples of concern must be escalated to the Medical Director. This list includes examples only and is not exhaustive. It can be helpful to refer to the thresholds for GMC referral as a reference for concerns that absolutely need immediate referral to the Medical Directors office. https://www.gmc-uk.org/-/media/documents/dc4528-guidance-gmc-thresholds_pdf-48163325.pdf

- A doctor's conduct or performance has been seen to fall below the standard set out in Good Medical Practice.
- A doctors performance and/or competencies are not at the level expected for the grade of locum engagement
- Where concerns arise and it is not clear if the doctor has a Responsible Officer (a doctor's RO can be checked via the GMC website).
- A doctor has shown a deliberate disregard of clinical or professional responsibilities
- A doctor has behaved dishonestly, fraudulently or in a way designed to mislead
- A doctors health may be compromising patient safety
- A doctors lack of knowledge of the English language could compromise patient safety

The Southern Trust Medical Director, the supervising consultant for the locum doctor along with the locum Doctor's Responsible Officer and Locum Agency will need to determine whether further investigation is carried out within the Trust or by the Locum Agency. The Medical Director may also seek advice from the GMC Employer Liaison Adviser. Where concerns relate to a clinical incident within Trust premises – then it is very likely that the Trust will be heavily involved in completing the investigation on behalf of the agency. (This is normally necessary to protect patient confidentiality.)

7. If a concern is found to be of such significance that it leads to an early termination of the locum engagement; the matter **MUST** be escalated to the Medical Director at the earliest opportunity with a copy of the documented concern also sent to the Head of Medical HR. All relevant information regarding the concern and the reason why the contract was terminated early, including the doctors response must be forwarded. This will be passed to the doctors Responsible Officer. The Medical Director will also need to have a discussion with the GMC Employer Liaison Adviser to consider if a GMC referral or an HSC Alert letter is required.

8. In all cases where there has been an established concern (whether or not this leads to an early termination or not) about a Locum doctor, the supervising consultant **MUST** complete the **LOCUM FEEDBACK/EXIT FORM**. See **Appendix.** This must provide a balanced view of how the concerns have been established. The purpose of this feedback is to ensure the Agency and Locum Doctors RO is aware of all the relevant information. It is important the doctor also receives a copy of this form as provision of feedback is important as it will be part of the evidence base that a locum doctor will need to provide for their annual appraisal as part of the revalidation process.

   The Southern Trust Medical Director will share these cases with the GMC Employer Liaison Adviser, so the individual doctor should also be made aware that the information may be shared with the GMC. As Clinical supervisor, you must complete this feedback form if you are not happy with a locum doctor, otherwise the agency is unable to deal with the issue and the doctor is unable to address any required changes in their behaviour, attitude or skills. If you don't, doctors with development needs will continue to move around the system without action being taken, putting patients and colleagues at risk. **It is ESSENTIAL that concerns are shared in this way rather than just a decision made to terminate a contract early or not to employ the locum doctor in the future.**

Advice and Guidance can be sought from the Medical Director and Head of Medical HR at any stage throughout this process so the management of all concerns is handled appropriately.

All referrals to the General Medical Council must be completed by the Trust Medical Director.

IN INSTANCES WHERE A LOCUM DOCTOR FAILS TO TURN UP FOR A SHIFT

If there is a concern that the locum doctor has failed to turn up for their shift without sufficient notice (& without a valid reason) you must document this concern (including the response given

by the doctor) to the Trust Medical Director with a copy also to the Medical Locum Team Manager. The Medical Locum Team Manager will pass this information to their locum agency/ Responsible Officer, as it could raise questions about their fitness to practice and adherence to the standards of Good Medical Practice or may be an indicator of other issues, such as health, which need to be addressed.

More Information/Guidance: https://view.pagetiger.com/Hub/doctors-in-difficulty-hub

Agency Locum Doctor

Feedback / Exit Form

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

External Agency Locum Feedback (Exit) Form

Locums Name:	Grade:
Specialty:	Hospital:
Dates from:	Dates to:

Please tick the appropriate boxes	Good to Excellent	Above Average	Average	Below Average	Poor	Not able to assess
CLINICAL SKILLS (Good Clinical Care)						
1. History Taking						
2. Physical examination & recognition of clinical signs						
3. Investigations & diagnosis						
4. Judgement and patient management						
5. Practical Skills						
KNOWLEDGE (Maintaining Good Medical Practice)						
1. Up to date Clinical knowledge						
ATTITUDES						
1. Reliability & Time keeping						
2. Leadership and Initiative						
3. Administration Skills						
RELATIONSHIPS (Working Relationships with Colleagues & Patients)						
1. Colleagues						
2. Patients						
3. Other Staff						
4. Team player						
5. Communication Skill						

PERSONAL QUALITIES							
1. Appearance							
2. Integrity							
3. Manners							
4. Confidentiality							
Teaching & Training	Willingness to contribute to education of students colleagues						

OTHER INFO		
Probity	Are you aware of any criminal convictions or cautions which may affect the applicant's suitability for a post?	Yes No
	Are you aware of any disciplinary proceedings which were upheld?	Yes No
Health	Are you aware of any health related issues?	Yes No
If yes to any of these questions, please give details:		

Where issues of concern have been raised this form will be shared with the doctor's agency and their Responsible Officer. Please ensure that details of clinical concerns/complaints are documented in full below. As best practice this should be shared with the doctor if possible.

DETAILS OF CONCERNS	
Does this doctor have a Responsible Officer?	Yes No
If so, do you know who the RO is?	
Have any Clinical Complaints been received?	Yes No
If **YES**, please give full details of the clinical concern: (were any incidents/near misses entered on Datix; were the incidents/near misses documented?)	
Was there a patient complaint regarding this doctor? Please provide copy if appropriate	
Was the clinical concern discussed with the doctor? Please provide full details of the doctor's response? (Enclose statement if necessary)	
Is the concern the reason you are letting the doctor go? Yes No If Yes: What are the risks if the doctor works in unrestricted practice?	
If a similar post became available within the Trust, would you consider re-employing this locum doctor again?	Yes No
If NO, please give details of why you would not re-employ the individual.	
If this doctor is part of the Southern Trust Internal Bank - Are you recommending precautionary suspension on the locum bank pending investigation? Y / N Yes – for this Specialty Yes – for ALL Specialties	
Is there any learning for the Trust re systems / human factors; were there any BME/fairness issues?	

Name		**Position Held**	
		Telephone Number	
Signature		**Date**	

Please Note:

- **Any concerns should be reported directly to the Medical Director and Medical Locums Team Office Manager**
- **All completed forms should be forwarded to: medicallocum.team @southerntrust.hscni.net**

Longer Term Locum Placement will require more detailed screening of concern Report

Strictly Private and Confidential

Southern Health and Social Care Trust

Screening of Concern

NAME OF AUTHOR
SPEICALTY, LOCATION
DATE

1. DETAILS OF THE CONCERN

This section should set out the specific concerns including what, where and when it happened, details of any Datix IR1s, SAIs, complaint letter and/or copy of the original complaint/concern, HCN Patient details and details of witnesses etc.

2. RESPONSE FROM THE DOCTOR

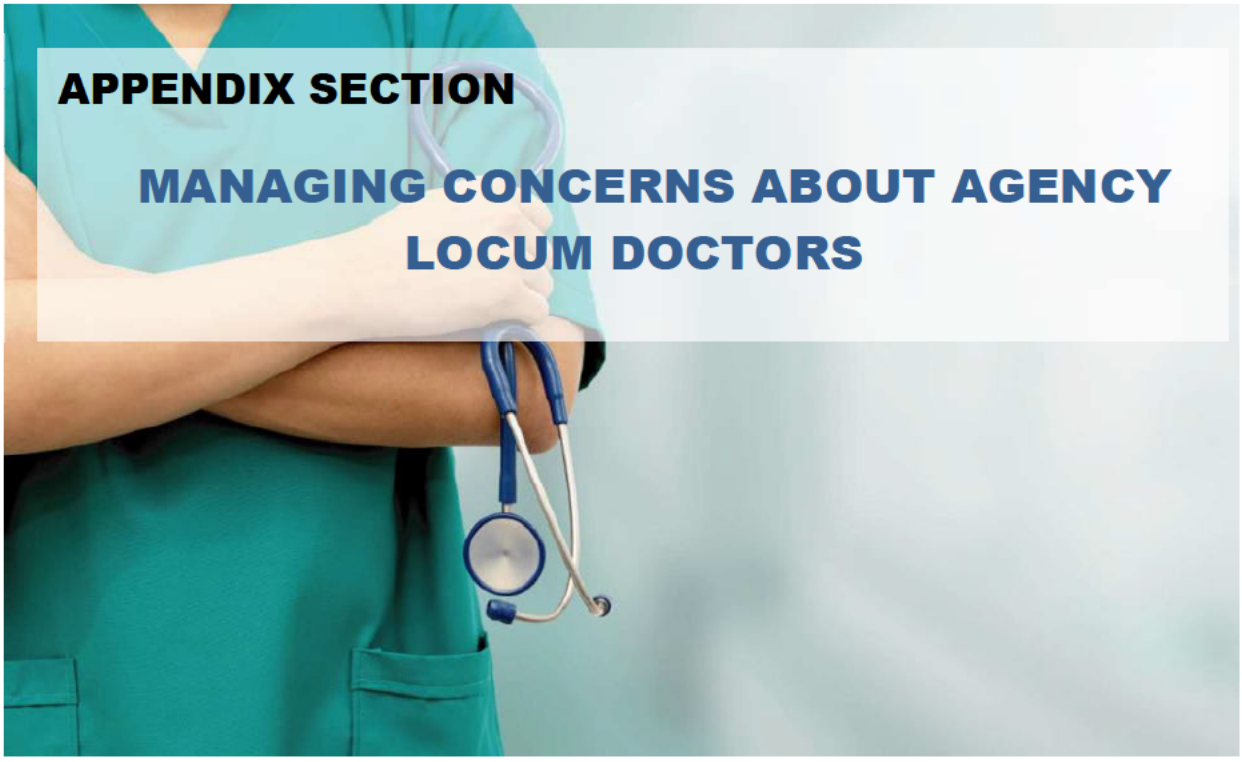
It is important a doctor is given the chance to respond to any allegations of concern (unless there is a suspicion of fraud). If Fraud is suspected, please contact Medical HR immediately. This section should include specific details of all meetings with the doctor and their initial responses to the concern.

3. SCOPING OF THE CONCERN

This section should set out what additional information was sought e.g. review of patient notes, review of records, views from others, view from the doctor etc. to verify or refute the original concern.

4. SCOPING OF CONCERN – CONCLUSION

This section should offer your conclusion to the quick gathering of facts that has completed to allow you to determine next steps. It will need to include enough information to enable a decision around continued engagement as a locum doctor and/or the need to alert the locum doctors Responsible Officer/GMC (both of which should be completed by the Trust Medical Director.



APPENDIX SECTION

MANAGING CONCERNS ABOUT AGENCY LOCUM DOCTORS

Diagnostic Frameworks

Sample Risk- Assessment Matrix

Sample Templates

Support Signposting

MANAGING CONCERNS ABOUT AGENCY LOCUM DOCTORS

'Model adapted from NACT UK Supporting Excellence in Medical Education 2018'

1) Early identification of problems and intervention is essential.

It is the responsibility of the entire team to highlight any concerns regarding a locum doctor

Useful 'Early Warning Signs', adapted from the book 'Understanding doctors' performance', may include:
The "disappearing act": not answering bleeps; disappearing; lateness; frequent sick leave.
Work rate: slowness in doing procedures, clerking patients, dictating letters, making decisions; arriving early, leaving late.
Ward rage: bursts of temper; shouting matches; real or imagined slights.
Rigidity: poor tolerance of ambiguity; inability to compromise; difficulty prioritising; inappropriate 'whistle blowing'.
Bypass syndrome: junior colleagues or nurses find ways to avoid seeking the doctor's opinion or help.
Career concerns: difficulty with exams; uncertainty about career choice; disillusionment with medicine.
Insight failure: rejection of constructive criticism; defensiveness; counter-challenge.
Lack of engagement in educational processes: fails to arrange appraisals, late with learning events/work-based assessments, reluctant to complete portfolio, little reflection
Lack of initiative/appropriate professional engagement: the doctor may come from a culture where there is a rigid hierarchical structure & are not encouraged to question patient management decisions by senior colleagues, or demonstrate any other healthy assertive behaviours
Inappropriate attitudes: The cultural background may be very strongly male oriented and the doctor may not be used to working with females on an equal status basis.

2) Establish and clarify the circumstances and facts as quickly as possible. Access many different sources of information

Most concerns can be addressed by early, effective discussions between the consultant and the Locum doctor culminating in a realistic plan, which is regularly reviewed to monitor success. An open and supportive culture should be encouraged within the whole clinical team, providing a sense of "belonging", fostering the development of the doctors' skills and providing constructive feedback on performance improvements or ongoing difficulties. Only form a judgement once all information is collated. Issues of patient and person safety take precedence over all other considerations.

3) Remember concern about performance is a 'symptom and not a diagnosis' and it is essential to explore the underlying cause or causes. *Key areas to explore are;*

i) Clinical performance of the individual: *(knowledge, skills, communication)*
ii) Personal, personality and behavioural issues: *(professionalism, motivation, cultural & religious issues)*
iii) Sickness / ill health: *(personal/family stress, career frustrations, financial)*
iv) Environmental issues: *(organisational, workload, "difficult" patients, bullying and harassment, staffing gaps, home stressors)*

4) A robust and detailed 'diagnosis' can lead to effective intervention: different problems require different solutions.

A doctor with an evolving medical problem, e.g. new diabetes or mental health issue, requires a different approach than an individual with poor interpersonal skills or lack of insight. The former needs engagement with health support (via their agency) and a GP, the latter perhaps supportive coaching & mentoring, close clinical supervision and feedback to change the beliefs behind the undesirable behaviour.

5) Clear documentation.

All relevant discussions and interventions with the locum doctor should be documented contemporaneously, communicated to the doctor and key individuals in the accountability framework (Clinical Director/Associate Medical Director/Responsible Officer) and followed up by named, accountable individuals to ensure the process is concluded satisfactorily and managed appropriately.

6) Issues must be communicated: Records must be kept: Solutions must be sought: It may be appropriate to delay progression until issues resolved BUT it is not appropriate to end a locum engagement without addressing concerns.

Received from SHSCT 05/05/2023. Annotated by the Urology Services Inquiry.

A Diagnostic Framework

MANAGING CONCERNS ABOUT AGENCY LOCUM DOCTORS

'Model adapted from NACT UK Supporting Excellence in Medical Education 2018'

'Events and Diagnostic Process'

Trigger event or incident

Investigate.
If serious, define the problem.
Collate evidence from as many sources as possible including from the individual concerned.
Be objective and document in detail

Decide
Is this a **Locum doctor** issue, an organisational issue or both?

If a Locum doctor issue, consider.. the following 3 questions
Does it matter?

If no, relax, If Yes, do something, next ask:

Can they normally do it?
If **no**, then is it a training issue or personal capability issue – is resolution possible within tenure of locum engagement? If not full details will need to be fed back to the locum agency on the Exit Form.
If **Yes**, the next question is…

'Why are they not doing 'it' now?'
Consider all possibilities. Is there:-

- a clinical performance issue
- a personality or behavioural issue
- a cultural background or religious issue
- a health and wellbeing issue
- an environmental issue

'Thoughts'

Is it important? Does it really matter? Who do I need to talk to or discuss this with? Consider other Colleagues, Clinical Director, Associate Medical Director, HR, Medical Director so they can advise Responsible Officer.

Think patient and person safety at all times! Do not jump to conclusions initially. Formulate your opinion as the information gathering proceeds.

This analysis is crucial as systems failure is often overlooked and it is easy to blame the locum doctor in isolation - try and resist this temptation! Be fair and objective.

Key areas to explore when considering trainee issues i.e. 'Potential Diagnoses'

i) clinical performance
ii) personal, personality and behavioural issues including impact of culture, attitude and religious background
iii) physical and mental health issues
iv) environmental issues including systems or process factors, organisational issues including lack of resources, home circumstances

MANAGING CONCERNS ABOUT AGENCY LOCUM DOCTORS

'Model adapted from NACT UK Supporting Excellence in Medical Education 2018'

SUPPORT CONSIDERATIONS

The interventions depend upon the underlying 'diagnosis' or 'diagnoses' revealed by the diagnostic framework above. In some cases, it may be possible to work with locum doctors to improve. However it is appreciated this is not always practical or possible give the length and nature of their engagements. Consultants must do what is possible to establish the nature of the concern.

- **Clinical Performance**

Some locum doctors may be under-performing in specific aspects of their role and this should be addressed directly to determine if this is a lack of skills/competence or linked to other organisational factors. This may require a period of clinical supervision or targeted training if this is feasible and/or appropriate in light of the locum engagement. For some locum doctors who are performing adequately at one level but not demonstrating their capability to perform at a higher level with more complex decision making, leadership skills and multi-tasking - this will require exploration with the doctor to make them aware of the concerns, determine if some additional training/supervision is feasible and/or If the concerns need to be fed back to the Locum Agency / Responsible Officer – via the Trust Medical Director.

- **Personality and behavioural issues**

Close supervision and some coaching/mentoring can help to provide a supportive environment to tackle issues of insight into behaviour. Seeking advice or involvement from colleagues of similar ethnicity, cultural or religious backgrounds to the locum doctor where appropriate, where such factors are relevant, can be crucial in resolution of problems relating to these factors. Sometimes problems persist and, remediation may prove unsuccessful or not be possible with short term locum engagements. A discussion with the locum doctor is important so they understand the concerns. The locum feedback Exit form must be completed to ensure the relevant and balanced information is fed back to the locum agency appropriately.

- **Health Issues – physical and mental**

Doctors become ill like all other individuals. Consider physical and mental health as well as substance misuse such as drugs or alcohol. "Good Medical Practice" requires doctors to seek and follow advice from a Consultant Occupational Physician if their judgement or performance might be affected by illness. Locum Doctors should be directed to contact their locum agency to determine if they have access to an Occupational Health Physician and/or their GP. Consider sign posting the locum doctor to the relevant support organisations (as detailed in this document) and ensure a Locum feedback Exit form is completed (in consultation with the Locum Doctor) so the Locum Agency is aware of the concern.

- **Environmental issues**

Organisational issues, including systems or process failures are often poorly acknowledged.
"Failures include lack of resources, such as poorly maintained equipment, inadequate secretarial support, computer equipment etc., unrealistic work demands, poor clinical management, poor support and substandard working environments." Locum doctors can be particularly affected by feelings of isolation from the team. All can prove to be confounding variables when other problems arise and can often precipitate a dramatic deterioration in performance and wellbeing. Consultants/Managers need to be proactive in escalating these issues within their organisations. In addition, consultants should also be sensitive to the locum doctors home circumstances. Delicate enquiry may lead to further discussion and better understanding. Alternatively, the situation may require signposting for specific support (see Appendix).

Document concerns, Share with Locum Doctor and Complete Feedback/Exit Form.

MANAGING CONCERNS ABOUT AGENCY LOCUM DOCTORS

*'**Model adapted from** "Supporting Doctors to Provide Safer Healthcare NHS Revalidation Support Team" 2013*

Risk Assessment Matrix

ESTABLISHING THE LEVEL OF CONCERN

This generic framework can be used to help establish the level of a concern. Use of a framework can improve consistency in response and management of concerns. Source https://www.england.nhs.uk/medical-revalidation/ro/resp-con/.

Definitions of level of concern:

- **Low level (Green) concern** = Concerns where there has been no harm to patients or staff and the doctor is not vulnerable or at any personal risk. Organisational or professional reputation is also not at stake but the concern needs to be addressed by discussion with the practitioner. This may include one of following; clinical incidents, complaints, poor outcome data which usually requires discussion and perhaps action.

- **Medium level (Amber) concern** = Concerns where there is a potential for serious harm to patients, staff or the doctor is at personal risk. Organisational or professional reputation may also be at stake. This may be a low level situation plus whistle blowing and requires definite discussion and an action plan.

- **High level (Red) concern** = Patients, staff or the doctor have been harmed. This may be a medium level situation plus a serious untoward incident or complaint requiring a formal investigation. This will also include things as serious as criminal acts and matters that must be escalated to the Medical Director for appropriate referrals to the GMC.

An example of a categorisation framework is given below:

Low Level Indictors	***Moderate Level Indicators***	***High Level Indicators***
Could the problem have been predicted?		
Unintended or unexpected incident		
What degree of interruption to service occurred?		
Incident may have interrupted the routine delivery of accepted practice (as defined by GMP) to one or more persons working or receiving care		Significant incident which interrups the routine delivery of accepted practice (as defined by GMP) to cone or more persons in or receiving care.
How likely is the problem to recur?		
Possibility of recurrence but any impact will remain minimal or low. Recurrence is not likely or certain.	Likelihood of recurrence may range from low to certain	Likelihood of recurrence may range from low to certain
How significant would a recurrence be?		
	Low level likelihood of recurrence will have a moderate impact (where harm has resulted as a direct consequence and will have affected the natural course of planned treatment or natural course of illness and is likely or certain to have resulted in moderate but not permanent harm.) Certain level likelihood of recurrence will have a minimal or low impact.	Low level likelihood of recurrence will have a high impact (where severe / permanent harm may result as a direct consequence and will affect the natural course of planned treatment or natural course of illness.

Low Level Indictors	***Moderate Level Indicators***	***High Level Indicators***
How much harm occurred?		
No harm to patients or staff and the doctor is not vulnerable or at any personal risk No requirement for treatment beyond that already planned.	Potential for harm to staff or the doctor is at personal risk. A member of staff has raised concerns about an individual which requires discussion and an action plan.	Patients, staff or the doctor have been harmed.
What reputational risks exist?		
Organisational or professional reputation is not at stake but the concern needs to be address by discussion with the practitioner.	Organisational or professional reputation may also be at stake	Organisational or professional reputation is at stake
Does the concern impact on more than one area of practice?		
Concern will be confined to a single domain of Good Medical Practice May include one of the following; clinical incidents, complaints, poor outcome data which requires discussion and perhaps action.	Concern affects more than one domain of Good Medical Practice. May include one or more of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	May include a serious untoward incident or complaint requiring a formal investigation. This will also ihclude serious concerns such as criminal acts and matters which must be escalated to the Medical Director for GMC referral.
What factors reduce levels of concern?		
	De-escalation from moderate to low: • Reduction to low or minimal impact • Reduction in the likelihood of recurrence • Evidence of completion of effective remediation.	De-escalation from high to moderate: • Reduction in impact to moderate • Reduction in the likelihood of recurrence • Evidence of insight and change in practice.

Low Level Indictors	***Moderate Level Indicators***	***High Level Indicators***
Which factors increase levels of concern?		
Escalation from low to moderate: • Increase in impact to moderate • Likelihood of recurrence is certain • No evidence of insight or change in practice	Escalation from moderate to high: • Increase in impact to severe • Increase in likelihood of recurrence • No evidence of remorse, insight or change in practice.	
How much intervention is likely to be required?		
Insight, remorse and change in practice will be evident. Remediation is likely to be achieved with peer support Individual doctor has no other involvement in incidents or outstanding/unaddressed complaints or concerns Remediation plan should take no longer than 4 weeks to address	Insight, remorse and change in practice may be evident Remediation is likely only to be achieved through specialist support The remediation plan should take no longer than 3 months to address	Remediation will only be achieved through specialist support The remediation plan will take upwards of 3 months to address and may include a planned period of supervised practice.

SAMPLE MEETING RECORD

Name:	Grade:	Date:
	Specialty:	Hospital:
Dates of Locum Engagement	From:	To:
Consultant/Manager:		

Concerns:	CONSIDER: ***Are they safe to practice?*** Yes / No If no: inform the CD/AMD and complete Locum Exit Feedback Form with doctor ***What are the issues?*** Clinical Performance Yes/No Personality / Behavioural Yes / No Physical Illness Yes / No Mental Illness Yes / No Environmental Issue Yes / No
Discussion:	
Way Forward:	

SAMPLE INDUCTION MEETING

Meeting date:	
Doctors Name:	
Consultant/Managers Name:	
Supervisors contact details:	
Start date of Locum Engagement:	
Intended Locum End Date:	
Last Revalidation date:	
Responsible Officer for Revalidation:	
Last Appraisal Date:	
ID Check completed against originals: Clinical Director / Associate Medical Director / Responsible Officer / Locum Agency / General Medical Council	

1. Knowledge, Skills and Performance: (Includes clinical competencies, qualifications, strengths and weaknesses)
2. Safety and Quality: (Includes complaints, incidents, significant events and audit, use of Datix)
3. Communication, Partnership and Team work: (Includes attitudes, attributes, relationships with patients, families, medical staff)
4. Maintaining Trust: (Includes patient respect and dignity, honesty and probity)

Consultant Supervisor Name / Signature:	
Locum Doctor Name / Signature:	

SAMPLE ACTION PLAN

Action Improvement Plans can be used where feasible or possible. It is appreciated it is not always possible to facilitate retraining/action planning with locum doctors, particularly those in short term engagements. However it is important to gather enough information to establish the nature of all concerns so these can be communicated appropriately and reported in a balanced way to the Locum Agency and Responsible Officer.

Define Need/Concern	Create 'SMART' Objective Improvement required	How will I address them? Action Taken	Date set to achieve goal	Date actually completed

Consider sign posting to additional support where appropriate.

Date discussed with Locum Doctor on:	
Date of Next Review:	
Involve (Circle if appropriate)	Clinical Director / Associate Medical Director / Responsible Officer / Locum Agency / General Medical Council
Completed by:	
Signed Locum Doctor:	

ADDITIONAL SUPPORT / RESOURCES

NHS Resolution	https://resolution.nhs.uk/contact/
Royal Medical Benevolent Fund	http://www.support4doctors.org
The Doctors Support Network (DSN)	Http://www.dsn.org.uk
Doctors Support Line – Volunteers	http://www.dloctorssupportline.org
Sick Doctors Trust	http://www.sick-doctoirs-trust.co.uk
The Psychiatrists Support Service	psychiatristssupportservice@rcpsych.ac.uk
Inspire	hello@inspirewellbeing.org
Advice and Guidance for Locum Doctors	https://www.england.nhs.uk/medicalrevalidation/doctors/locum-ad/
Other Support on BMA Site	https://www.bma.org.uk/advice/work-life-support/your wellbeing/sources-of-support
GMC Support for Doctors	https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors

Reference documents

https://www.nhsemployers.org/~/media/Employers/Publications/Guidance-on-the-appointment-and-employment-of-locum-doctors.pdf

https://www.england.nhs.uk/wp-content/uploads/2018/10/supporting_locum_agencies_and_providers.pdf

https://www.gmc-uk.org/registration-and-licensing/employers-medical-schools-and-colleges/employing-a-doctor.

https://www.gov.uk/government/publications/code-of-practice-appointment-and-assessment-of-locum-doctors

2018

Southern Health and Social Care Trust

Quality Care - for you, with you

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

October 2017

INTRODUCTION

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

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

1.3 MHPS is in six sections and covers:

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

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

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

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

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

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

Annex A
"Maintaining High Professional Standards in the Modern NHS" DHSSPS, 2005
Annex B
"How to conduct a local performance investigation" NCAS, 2010
Annex C
SHSCT Disciplinary Procedure
Annex D
SHSCT Bullying and harassment Procedure

2.0 WHAT IS A CONCERN?

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

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

MHPS Section1 para 2

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

- Failure to report concerns

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

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

2.5 WHO TO TELL?

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

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

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

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

3.1 AS CLINICAL MANAGER - WHAT ACTION DO I TAKE?

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

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

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

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

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

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

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

3.2 DIFFERENCE BETWEEN SCREENING OF CONCERNS AND FORMAL INVESTIGATION

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

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

3.3 SUPPORT FOR DOCTORS DURING SCREENING

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

3.4 WHAT HAPPENS AT THE END OF SCREENING PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 SUMMARY

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

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

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

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

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

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

Appendix 6
Role definitions

Appendix 1

Step 1 Screening Process

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

→ Clinical Manager/Operational Director informs

Early in process
- Practitioner

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

↓

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

↓

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

↓

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

→ No Action Necessary, Reason documented and held on file

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

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

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

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

Appendix 1

Informal Remedial Action

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

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

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

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

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

Referral to NCAS

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

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

Appendix 2

Formal Investigation Process

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

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

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

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

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

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

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

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

Case Manager must then make a decision on whether:

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

Appendix 3

Outcome of Formal Investigation:
Conduct Hearings / Disciplinary Procedures

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

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

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

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

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

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

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

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

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

Appendix 3a

Outcome of Formal Investigation:
Clinical Performance Hearings

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

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

↓

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

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

↓

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

↓

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

↓

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

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

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

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

Appendix 3a

Clinical Performance Hearings

During the hearing:

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

During the hearing - witnesses:

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

During the hearing – order of presentation:

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

Decision of the panel may be:

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

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

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

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

Appendix 4

Appeal Procedures in Clinical Performance Cases

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

Composition of the panel – 3 people:

- **Chair**

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

- **Panel 1**

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

- **Panel 2**

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

Advisors to the Panel:

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

Timescales:

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

Powers of the Appeal Panel

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

Documentation:

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

Appendix 5

Restriction of Practice / Exclusion from Work

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

Immediate Exclusion

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

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

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

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

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

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

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

Appendix 5

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

Formal Exclusion

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

↓

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

→

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

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

↓

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

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

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

↓

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

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

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

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

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

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

Formal Process

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

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

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

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

Non Executive Board Member

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

Classifying Concerns and considering Risk

Southern Health and Social Care Trust

Quality Care - for you, with you

Guidance for Clinical Managers

Zoe Parks: Head of Medical HR

2021

Significant concerns should be documented in a Screening of Concern document O particularly when they reach the threshold for referral to Associate Medical Director / Medical Director and Responsible Officer.

Strictly Private and Confidential

Southern Health and Social Care Trust

Screening of Concern

NAME OF AUTHOR
SPEICALTY, LOCATION
DATE

1. **DETAILS OF THE CONCERN**

This section should set out the specific concerns including what, where and when it happened, details of any Datix IR1s, SAIs, complaint letter and/or copy of the original complaint/concern, HCN Patient details and details of witnesses etc.

2. **RESPONSE FROM THE DOCTOR**

It is important a doctor is given the chance to respond to any allegations of concern (unless there is a suspicion of fraud). If Fraud is suspected, please contact Medical HR immediately before any contact with the doctor. This section should include specific details of all meetings with the doctor and a copy of their initial response(s) to the concern.

3. **SCOPING OF THE CONCERN**

This section should set out what additional information was sought e.g. review of patient notes, review of records, views from others, view from the doctor etc. to verify or refute the original concern.

4. **SCOPING OF CONCERN – CONCLUSION**

This section should offer your conclusion to the quick gathering of facts that has completed to allow you to determine next steps. It will need to include enough information to enable a decision around how the concern will be handled (e.g. informally, via mediation, action plan or if it should be referred for formal investigation.) The Medical Directors Office can take forward appointment of relevant Case Investigators and Case Managers under Maintaining High Professional Framework for formal investigations. Taking the decision of whether a concern meets the threshold for escalation is not easy and shouldn't be taken along. Clinical managers should seek advice from Medical HR and/or Medical Directors office as necessary.

Sample Risk-Assessment Matrix's

Managing Disruptive Behaviours

Sample Templates

Support Signposting

MANAGING CONCERNS ABOUT DOCTORS

'Model adapted from NACT UK Supporting Excellence in Medical Education 2018'

1) Early identification of problems and intervention is essential.

It is the responsibility of the entire team to highlight any concerns regarding a doctor

Useful 'Early Warning Signs', adapted from the book 'Understanding doctors' performance', may include:
The "disappearing act": not answering bleeps; disappearing; lateness; frequent sick leave.
Work rate: slowness in doing procedures, clerking patients, dictating letters, making decisions; arriving early, leaving late.
Ward rage: bursts of temper; shouting matches; real or imagined slights.
Rigidity: poor tolerance of ambiguity; inability to compromise; difficulty prioritising; inappropriate 'whistle blowing'.
Bypass syndrome: junior colleagues or nurses find ways to avoid seeking the doctor's opinion or help.
Career concerns: difficulty with exams; uncertainty about career choice; disillusionment with medicine.
Insight failure: rejection of constructive criticism; defensiveness; counter-challenge.
Lack of engagement in educational processes: fails to arrange appraisals, late with learning events/work-based assessments, reluctant to complete portfolio, little reflection
Lack of initiative/appropriate professional engagement: the doctor may come from a culture where there is a rigid hierarchical structure & are not encouraged to question patient management decisions by senior colleagues, or demonstrate any other healthy assertive behaviours
Inappropriate attitudes: The cultural background may be very strongly male oriented and the doctor may not be used to working with females on an equal status basis.

2) Establish and clarify the circumstances and facts as quickly as possible. Access many different sources of information

Most concerns can be addressed by early, effective discussions between the consultant and the doctor culminating in a realistic plan, which is regularly reviewed to monitor success. An open and supportive culture should be encouraged within the whole clinical team, providing a sense of "belonging", fostering the development of the doctors' skills and providing constructive feedback on performance improvements or ongoing difficulties. Only form a judgement once all information is collated. Issues of patient and person safety take precedence over all other considerations.

3) Remember concern about performance is a 'symptom and not a diagnosis' and it is essential to explore the underlying cause or causes. *Key areas to explore are;*

i) Clinical performance of the individual: *(knowledge, skills, communication)*
ii) Personal, personality and behavioural issues: *(professionalism, motivation, cultural & religious issues)*
iii) Sickness / ill health: *(personal/family stress, career frustrations, financial)*
iv) Environmental issues: *(organisational, workload, "difficult" patients, bullying and harassment, staffing gaps, home stressors)*

4) A robust and detailed 'diagnosis' can lead to effective intervention: different problems require different solutions.

A doctor with an evolving medical problem, e.g. new diabetes or mental health issue, requires a different approach than an individual with poor interpersonal skills or lack of insight. The former needs engagement with health support (via their agency) and a GP, the latter perhaps supportive coaching & mentoring, close clinical supervision and feedback to change the beliefs behind the undesirable behaviour.

5) Clear documentation.

All relevant discussions and interventions with the doctor should be documented contemporaneously, communicated to the doctor and key individuals in the accountability framework (Clinical Director/Associate Medical Director/Responsible Officer) and followed up by named, accountable individuals to ensure the process is concluded satisfactorily and managed appropriately.

6) Issues must be communicated: Records must be kept: Solutions must be sought: It may be appropriate to delay progression until issues resolved

A Diagnostic Framework

MANAGING CONCERNS ABOUT DOCTORS

'Model adapted from NACT UK Supporting Excellence in Medical Education 2018'

'Events and Diagnostic Process'

Trigger event or incident

Investigate.
If serious, define the problem.
Collate evidence from as many sources as possible including from the individual concerned.
Be objective and document in detail

Decide
Is this a **doctor** issue, an organisational issue or both?

If a doctor issue, consider.. the following 3 questions
Does it matter?

If no, relax, If Yes, do something, next ask:

Can they normally do it?
If **no**, then is it a training issue or personal capability issue – is resolution possible within tenure of employment? If not full details will need to be fed back to the RO.
If **Yes**, the next question is...

'Why are they not doing 'it' now?'
Consider all possibilities. Is there:-

- a clinical performance issue
- a personality or behavioural issue
- a cultural background or religious issue
- a health and wellbeing issue
- an environmental issue

'Thoughts'

Is it important? Does it really matter? Who do I need to talk to or discuss this with? Consider other Colleagues, Clinical Director, Associate Medical Director, HR, Medical Director so they can advise Responsible Officer.

Think patient and person safety at all times! Do not jump to conclusions initially. Formulate your opinion as the information gathering proceeds.

This analysis is crucial as systems failure is often overlooked and it is easy to blame the doctor in isolation - try and resist this temptation! Be fair and objective.

Key areas to explore when considering trainee issues i.e. 'Potential Diagnoses'

i) clinical performance
ii) personal, personality and behavioural issues including impact of culture, attitude and religious background
iii) physical and mental health issues
iv) environmental issues including systems or process factors, organisational issues including lack of resources, home circumstances

MANAGING CONCERNS ABOUT DOCTORS

'Model adapted from NACT UK Supporting Excellence in Medical Education 2018'

SUPPORT CONSIDERATIONS

The interventions depend upon the underlying 'diagnosis' or 'diagnoses' revealed by the diagnostic framework above. In some cases, it may be possible to work with doctors to improve. Consultants must do what is possible to establish the nature of the concern.

- **Clinical Performance**

Some doctors may be under-performing in specific aspects of their role and this should be addressed directly to determine if this is a lack of skills/competence or linked to other organisational factors. This may require a period of clinical supervision or targeted training if this is feasible and/or appropriate. For some doctors who are performing adequately at one level but not demonstrating their capability to perform at a higher level with more complex decision making, leadership skills and multi-tasking - this will require exploration with the doctor to make them aware of the concerns, determine if some additional training/supervision is feasible and/or If the concerns need to be fed back to the Responsible Officer.

- **Personality and behavioural issues**

Close supervision and some coaching/mentoring can help to provide a supportive environment to tackle issues of insight into behaviour. Seeking advice or involvement from colleagues of similar ethnicity, cultural or religious backgrounds to the doctor where appropriate, where such factors are relevant, can be crucial in resolution of problems relating to these factors. Sometimes problems persist and, remediation may prove unsuccessful or not be possible. A discussion with the doctor is important so they understand the concerns.

- **Health Issues – physical and mental**

Doctors become ill like all other individuals. Consider physical and mental health as well as substance misuse such as drugs or alcohol. "Good Medical Practice" requires doctors to seek and follow advice from a Consultant Occupational Physician if their judgement or performance might be affected by illness. Consider sign posting the doctor to the relevant support organisations.

- **Environmental issues**

Organisational issues, including systems or process failures are often poorly acknowledged. ***"Failures include lack of resources, such as poorly maintained equipment, inadequate secretarial support, computer equipment etc, unrealistic work demands, poor clinical management, poor support and substandard working environments."*** Doctors can sometimes be affected by feelings of isolation from the team. All can prove to be confounding variables when other problems arise and can often precipitate a dramatic deterioration in performance and wellbeing. Consultants/Managers need to be proactive in escalating these issues within their organisations. In addition, consultants should also be sensitive to the doctor's home circumstances. Delicate enquiry may lead to further discussion and better understanding. Alternatively, the situation may require signposting for specific support.

Always Document concerns for your own records, Share with Doctor and decide on next steps

MANAGING CONCERNS ABOUT DOCTORS

*'**Model adapted from** "Supporting Doctors to Provide Safer Healthcare NHS Revalidation Support Team" 2013*

Risk Assessment Matrix

ESTABLISHING THE LEVEL OF CONCERN

This generic framework can be used to help establish the level of a concern. Use of a framework can improve consistency in response and management of concerns. Source https://www.england.nhs.uk/medical-revalidation/ro/resp-con/.

Definitions of level of concern:

Low level (Green) concern

Concerns where there has been no harm to patients or staff and the doctor is not vulnerable or at any personal risk. Organisational or professional reputation is also not at stake but the concern needs to be addressed by discussion with the practitioner. This may include one of following; clinical incidents, complaints, poor outcome data which usually requires discussion and perhaps action.

Medium level (Amber) concern

Concerns where there is a potential for serious harm to patients, staff or the doctor is at personal risk. Organisational or professional reputation may also be at stake. This may be a low level situation plus whistle blowing and requires definite discussion and an action plan.

High level (Red) concern

Patients, staff or the doctor have been harmed. This may be a medium level situation plus a serious untoward incident or complaint requiring a formal investigation. This will also include things as serious as criminal acts and matters that must be escalated to the Medical Director for appropriate referrals to the GMC.

An example of a categorisation framework is given below:

Low Level Indictors	***Moderate Level Indicators***	***High Level Indicators***
Could the problem have been predicted?		
Unintended or unexpected incident		
What degree of interruption to service occurred?		
Incident may have interrupted the routine delivery of accepted practice (as defined by GMP) to one or more persons working or receiving care		Significant incident which interrups the routine delivery of accepted practice (as defined by GMP) to cone or more persons in or receiving care.
How likely is the problem to recur?		
Possibility of recurrence but any impact will remain minimal or low. Recurrence is not likely or certain.	Likelihood of recurrence may range from low to certain	Likelihood of recurrence may range from low to certain
How significant would a recurrence be?		
	Low level likelihood of recurrence will have a moderate impact (where harm has resulted as a direct consequence and will have affected the natural course of planned treatment or natural course of illness and is likely or certain to have resulted in moderate but not permanent harm.) Certain level likelihood of recurrence will have a minimal or low impact.	Low level likelihood of recurrence will have a high impact (where severe / permanent harm may result as a direct consequence and will affect the natural course of planned treatment or natural course of illness.

Low Level Indictors	***Moderate Level Indicators***	***High Level Indicators***
How much harm occurred?		
No harm to patients or staff and the doctor is not vulnerable or at any personal risk No requirement for treatment beyond that already planned.	Potential for harm to staff or the doctor is at personal risk. A member of staff has raised concerns about an individual which requires discussion and an action plan.	Patients, staff or the doctor have been harmed.
What reputational risks exist?		
Organisational or professional reputation is not at stake but the concern needs to be address by discussion with the practitioner.	Organisational or professional reputation may also be at stake	Organisational or professional reputation is at stake
Does the concern impact on more than one area of practice?		
Concern will be confined to a single domain of Good Medical Practice May include one of the following; clinical incidents, complaints, poor outcome data which requires discussion and perhaps action.	Concern affects more than one domain of Good Medical Practice. May include one or more of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	May include a serious untoward incident or complaint requiring a formal investigation. This will also ihclude serious concerns such as criminal acts and matters which must be escalated to the Medical Director for GMC referral.
What factors reduce levels of concern?		
	De-escalation from moderate to low: • Reduction to low or minimal impact • Reduction in the likelihood of recurrence • Evidence of completion of effective remediation.	De-escalation from high to moderate: • Reduction in impact to moderate • Reduction in the likelihood of recurrence • Evidence of insight and change in practice.

Low Level Indictors	*Moderate Level Indicators*	*High Level Indicators*
Which factors increase levels of concern?		
Escalation from low to moderate: • Increase in impact to moderate • Likelihood of recurrence is certain • No evidence of insight or change in practice	Escalation from moderate to high: • Increase in impact to severe • Increase in likelihood of recurrence • No evidence of remorse, insight or change in practice.	
How much intervention is likely to be required?		
Insight, remorse and change in practice will be evident. Remediation is likely to be achieved with peer support Individual doctor has no other involvement in incidents or outstanding/unaddressed complaints or concerns Remediation plan should take no longer than 4 weeks to address	Insight, remorse and change in practice may be evident Remediation is likely only to be achieved through specialist support The remediation plan should take no longer than 3 months to address	Remediation will only be achieved through specialist support The remediation plan will take upwards of 3 months to address and may include a planned period of supervised practice.

GRADED RESPONSES TO MANAGING DISRUPTIVE BEHAVIOURS

The Vanderbilt University School of Medicine in the US has advocated a model for addressing disruptive behaviour focused on four graduated interventions:

- **Informal conversations for single incidents** – including the 'cup of coffee conversation'. There are exceptions, such as when the law mandates reporting the event and/ or provides sanctions for engaging in prohibited behaviour. At Vanderbilt, training in having a 'cup of coffee conversation' is based on the principles of sharing bad news.

- **Non-punitive 'awareness' interventions when data reveal a pattern that sets the individual apart from their peers** – the pattern must be presented by an authority figure or, in some circumstances, by a peer.

- **Leader-developed action plans if patterns persist** – a small proportion of professionals seem unable or unwilling to respond to an awareness intervention and require an 'authority intervention'.

- **Imposition of disciplinary processes if the plans fail** – including restrictions on practice or even termination of contract. Box 9: Questions to ask about an incident of disruptive behaviour The College of Physicians and Surgeons of Ontario and Ontario Hospital Association suggests the following questions to understand the incident:

Box 9: Questions to ask about an incident of disruptive behaviour

The College of Physicians and Surgeons of Ontario and Ontario Hospital Association suggests the following questions to understand the incident:[8]

- Did this incident represent a change in the physician's previous behaviour pattern?
- Does the potentially problematic behaviour appear to be increasing in frequency?
- Was the behaviour accompanied with an appropriate degree of emotion?
- Does the behaviour appear to be broadening in scope over time to include more than one 'index' behaviour?

Arrange a face-to-face meeting to discuss problematic behaviour – these conversations can be difficult and making them effective is critical.[8]

Plan well for the meeting – consider the setting, whether it would be advisable to have a third party attend, how long the meeting will last, and the desired outcome.

Follow the format of a performance appraisal – thank the doctor for attending, lay out the rules of engagement, begin with a statement of recognition of the things that the doctor does well, provide full details of the concerning incidents, close with a discussion of the steps to be taken to measure success and plan the next meeting.[8]

Avoid trying to soften the message – by mixing it with complimentary statements or using an overly familiar tone.[53]

Stage one	Stage two	Stage three
The kinds of behaviour that might require a stage one intervention include a single/limited instances of relatively mild disruptive behaviour, such as use of inappropriate language, an outburst of anger, demeaning comments or intimidation, a single instance of throwing/ breaking objects, refusal to follow hospital policies. The appropriate response will depend on how serious the behaviour is, the context, and the physician's response. Whatever the outcome, a note should be retained on file about the discussion held with the physician.	A stage two approach is most often required after stage one interventions have failed to result in sustained behavioural changes. In order to determine how best to change the behaviour, there needs to be some understanding of what is causing or contributing to it. An external assessment may be helpful. Once the underlying cause of the problem has been identified, the organisation and the physician should agree on the next steps. A therapeutic approach may be required, for example to address stress management or addiction issues. In other cases, a more educational approach will be effective.	Stage three describes inappropriate behaviour that has persisted or escalated despite intervention. For example, physical assault or sexual advances towards colleagues; behaviours attributable to impairment caused by mental illness or substance use; and behaviour that contravenes laws and/or gives rise to an obligation to report the behaviour to the police or regulators. The process for review and discussion with the physician still apply. In addition, the behaviour must be brought to the attention of senior authorities and formality of process is needed due to the possibility that restrictions on practice may be needed.

Figure 4: *College of Physicians and Surgeons of Ontario and Ontario Hospital Association staged approach.*

Stage one	Stage two	Stage three	Stage four
(low severity)	(moderate severity)	(medium to high severity)	(high severity)
First report of disruptive behaviour (although may not be first incident).	Repeated stage one behaviour, despite intervention; escalation in frequency and severity; sexualised behaviour (even if the first incident).	Persistent disruptive conduct beyond moderate severity; serious conduct that raises concerns of harm to the individual or others.	Behaviour beyond stage three that includes threats or attempts to harm self or others, significant legal liability, immediate risk of patient injury.

Figure 5: *College of Physicians and Surgeons of Alberta four-stage process.*[13]

SAMPLE MEETING RECORD

Name:	Grade:	Date:
	Specialty:	Hospital:
Dates of Engagement	From:	To:
Consultant/Manager:		

Concerns:	CONSIDER: ***Are they safe to practice?*** Yes / No If no: inform the CD/AMD for escalation to MD/RO ***What are the issues?*** Clinical Performance Yes/No Personality / Behavioural Yes / No Physical Illness Yes / No Mental Illness Yes / No Environmental Issue Yes / No
Discussion:	
Way Forward:	

SAMPLE MEETING

Meeting date:	
Doctors Name:	
Consultant/Managers Name:	
Supervisors contact details:	
Start date of Engagement:	
Intended End Date:	
Last Revalidation date:	
Responsible Officer for Revalidation:	
Last Appraisal Date:	
ID Check completed against originals: Clinical Director / Associate Medical Director / Responsible Officer / Locum Agency / General Medical Council	

1. Knowledge, Skills and Performance: (Includes clinical competencies, qualifications, strengths and weaknesses)
2. Safety and Quality: (Includes complaints, incidents, significant events and audit, use of Datix)
3. Communication, Partnership and Team work: (Includes attitudes, attributes, relationships with patients, families, medical staff)
4. Maintaining Trust: (Includes patient respect and dignity, honesty and probity)

Consultant Supervisor Name / Signature:	
Doctor Name / Signature:	

SAMPLE ACTION PLAN

Action Improvement Plans can be used where feasible or possible. It is appreciated it is not always possible to facilitate retraining/action planning with doctors, particularly those in short term engagements. However it is important to gather enough information to establish the nature of all concerns so these can be communicated appropriately and reported in a balanced way to the Responsible Officer.

Define Need/Concern	Create 'SMART' Objective Improvement required	How will I address them? Action Taken	Date set to achieve goal	Date actually completed

Consider sign posting to additional support where appropriate.

Date discussed with Doctor on:	
Date of Next Review:	
Involve (Circle if appropriate)	Clinical Director / Associate Medical Director / Responsible Officer / Locum Agency / General Medical Council
Completed by:	
Signed Doctor:	

ADDITIONAL SUPPORT / RESOURCES

NHS Resolution	https://resolution.nhs.uk/contact/
Royal Medical Benevolent Fund	http://www.support4doctors.org
The Doctors Support Network (DSN)	Http://www.dsn.org.uk
Doctors Support Line – Volunteers	http://www.dloctorssupportline.org
Sick Doctors Trust	http://www.sick-doctoirs-trust.co.uk
The Psychiatrists Support Service	psychiatristssupportservice@rcpsych.ac.uk
Inspire	hello@inspirewellbeing.org
Advice and Guidance for Locum Doctors	https://www.england.nhs.uk/medicalrevalidation/doctors/locum-ad/
Other Support on BMA Site	https://www.bma.org.uk/advice/work-life-support/your wellbeing/sources-of-support
GMC Support for Doctors	https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors

Reference documents

https://www.nhsemployers.org/~/media/Employers/Publications/Guidance-on-the-appointment-and-employment-of-locum-doctors.pdf

https://www.england.nhs.uk/wp-content/uploads/2018/10/supporting_locum_agencies_and_providers.pdf

https://www.gmc-uk.org/registration-and-licensing/employers-medical-schools-and-colleges/employing-a-doctor.

https://www.gov.uk/government/publications/code-of-practice-appointment-and-assessment-of-locum-doctors

Southern Health and Social Care Trust

Quality Care - for you, with you

MEDICAL REVALIDATION OVERSIGHT GROUP

TERMS OF REFERENCE (20th April 2021)

Purpose

Medical revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practice. A cornerstone of the revalidation process is that doctors participate in annual medical appraisal. On the basis of this and other information available to the Trust Responsible Officer (RO) from local clinical governance systems and additional feedback mechanisms, the RO makes a recommendation to the GMC, normally once every five years, about the doctor's revalidation.

The purpose of the Trust Medical Revalidation Group (the Group) is to provide a forum for Trust Medical Senior Management Team members to consider and inform decision regarding medical revalidation of Trust licensed doctors.

Aim and Objectives

The aim of the Group is to ensure that decisions regarding Medical Revalidation are consistent, robust and quality assured by the relevant Trust Senior Medical Leader. To meet this aim each relevant Associate Medical Director / Divisional Medical Director for doctors under their leadership will:

- Provide assurance that opportunities for reflection, learning and development e.g. significant events and complaints have been adequately discussed and reflected on appropriately at appraisal
- Ensure there is has been a formative approach taken to the doctors appraisal process and there has been an appropriate level of engagement by the doctor
- Ensure outputs are adequate and identify if additional time is required to review a doctor's portfolio before the RO's decision prior to the revalidation recommendation date
- Assure that all summaries from all sources accurately reflect the doctor's work and if the documentation is inadequate, advise the responsible officer allowing for an informed decision to be made regarding a recommendation for revalidation

- Bring to the attention of the RO any additional information that has not been captured in other sources that require the consideration of the RO prior to making a revalidation recommendation.

Membership

Members of the group shall be made up of:

- Medical Director (Chair)
- Deputy Medical Directors
- All operational Associate Medical Directors / Divisional Medical Directors
- Assistant Director – Medical Directors Office

Others may be invited by the Chair to attend all or part of any meeting as and when appropriate and necessary.

Quorum

The quorum necessary for the meeting will be each AMD / DMD or nominated deputy for each operational area.

Members should aim to attend all meetings.

Frequency of Meetings

The Group shall meet via Zoom on a monthly basis.

Group members will receive agenda and papers confidential to their area no less than five working days in advance of the meeting.

Stinson, Emma M

From: Kingsnorth, Patricia
Sent: 02 May 2023 14:52
To: Stinson, Emma M
Subject: FW: Expert Urology opinion
Attachments: KS.PK 23.02.21.doc; Review spreadsheet - Sethia.xlsx

From: Sethia, Krishna (NNUHFT) [redacted]
Sent: 23 February 2021 11:07
To: Kingsnorth, Patricia [redacted]
Cc: Julia Moye [redacted]
Subject: Expert Urology opinion

Dear Patricia

Please see attached letter and form. I will send the password separately

Kind regards

Krishna

By email only Patricia.Kingsnorth Personal Information redacted by the USI

23 February 2021

Dear Patricia

I have now reviewed the notes that David sent over and I have completed the spreadsheet that Martina sent, which I hope is helpful. I have not seen the full notes of Patient 101 Patient 101.

With regard to them being designated as serious incidents I am pleased to say that whilst their management was not always conventional or correct I do not think there is any definite evidence of harm having been done (but see below).

There are two cases of delays in management (Patient 96 Patient 97), two of failure to discuss at the MDM Patient 98, Patient 100) - these all represent substandard care. There are three cases (including Patient 101) of the unconventional use of bicalutamide.

The three cases where Mr O'Brien prescribed bicalutamide Patient 58, Patient 100 and Patient 101) do raise the question of whether he should have offered earlier radiotherapy. This would certainly have been better practice so the patients were denied the chance of discussing the options properly.My thoughts are

1. Patient 58 - Prognosis remains good so although perhaps a candidate for radiotherapy in 2017 no harm done.
2. Patient 100 - Might have been candidate for radiotherapy in 2013. This might have conferred a small survival advantage at 10 years but he is doing well.
3. Patient 101 - should have started radiotherapy in Feb 2020 - therefore 6 month delay. Probably no harm.

I hope these comments are helpful. Do let me know if you need me to elaborate

Kind regards

Krishna

Professor Krishna Sethia DM FRCS
Consultant Urological Surgeon
Norfolk & Norwich University NHS Trust

Demographic information			Regarding patient's current care			While under Mr O'Briens care please answer the following to the best of your knowledge						
HCN	Name	Date of birth	Is the present diagnosis secure	is the current prescribed treatment appropriate?	Is a secure clinical management plan currently in place?	Where appropriate Investigations carried out?	Was the Prescribed treatment appropriate at the time/ is it appropriate now?	Was the Diagnosis secure?	Was the Clinical Management approach taken reasonable?	Was there unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc)?	Do you have reason to believe the problem led to harm?	Comments
	Patient 96		Yes	Yes	Yes	Yes	Yes	As secure as it could have	Yes until December 2019	No action after December 2019 N	No	Delay in arranging biosies after MRI in December 2019 but no harm done
	Patient 58		Yes			Yes	No - no resaon to start bicalutamice in May	Yes	No	No	See comments	Might have been candidate for radiotherapy in 2017 but clinical situation complicated by prostate size and symptoms. Bicalutamide was an unconventional treatment but has probaby not resulted in harm
	Patient 97		Yes	Yes	Yes	Yes until May 2020	Yes	see comment		Yes - no cystoscopy arranged in N	No	6 month delay in arranging cystoscopy. As it happens tests were normal so no harm done.
	Patient 98		Yes	Yes	Yes	Yes	Yes	Yes	Yes	No clear follow-up plan between :	No	Low risk disease. Mr O'Brien should have reviewed case at MDM but plan would have been the same.
	Patient 99		Yes	Yes	Yes	Yes	Yes	Yes	Yes	MMC delayed by Covid	No	No criticism of management
	Patient 100		Yes	Yes	Yes	Yes in 2010 but then no reci	He was satrted on bicalutamide in 2013 - thi	Yes	No	Gap in follow-up between 2010 a	No	No record of MDM discussion. Unclear why bicalutamide started in 2013 - if his tumour was progressing he would have been a candidate for radiotherapy

Southern Health and Social Care Trust

Incident Oversight Group

Tuesday 20th October 2020, 5:00pm

Via Zoom

AGENDA

No	Item	Documents
1	Apologies	
2	Review of Action Log	
3	Update on Communications with PHA / HSCB / DoH	
4	Any Other Business	
5	Date of Next Meeting 27th October 2020	

Incident Management

ID	Element	Actions Required	Responsible	Date for Completion	Attachments	Complete
1	Development of Preannouncement communications plan	Identification of who needs to be contacted, by which method, by whom and when: - AOB to inform of ministerial release - GMC - SAI Chair Dermot Hughes - Tom Black, BMA - Internal Comms to Medical Leaders / Doctors - Internal Comms to Urology team (all team members) - GP / HSCB - NHS Resolutions				
1	GMC Request for Information 8th October 2020	Further communication received from the GMC asking for update on issues. Draft corresepondence created for review. GMC to be advised of decision not to progress with MHPS review based on DoH advice.	M O'Kane / S Wallace			Complete
2	MHPS Investigation (New)	AOB is no longer professionally accountable to the SHSCT and Dr O'Kane is not responsible officer - this has been the case since 29th July 2020. Response from AOB solictor 9th September stating that as MHPS did not start prior to AOB's retirement that there are no grounds for continuing the process. DLS advice has been dou on AOB solictor communcation. DoH have also advised that given AOBs retirement MHPS should not be followed. GMC to be updated	M O'Kane / S Hynds / S Wallace	30th September		Complete
3	Mileage Claims	AOB has submitted mileage claims for previous 8 years prior to retirement. AOB's contract states that this should be monthly submissions. SH stated that communications had been issued to staff at regular intervals to remind of the importance of prompt submission. Group agreed that April 2020 would be reasonable for consideration following verification.	M McClements / R Carroll / M Corrigan	20th October		In progress
4	Administration Review	Dr Rose McCullagh and Dr Mary Donnelly are conducting an administrative process review as specified in the 2018 MHPS review outcome. MC discussed with Anita Carroll to conduct SOP process review to complement the review . Report due to be presented to the Director of Acute Services. MMcC requested follow up on actions from 5 SAI's that were conducted by Dr Julian Johnston. MC linking in with team	R McCullagh / M Donnelly	20th October		In progress
5	Screening of potential SAIs	Eight SAIs screened and meet the requirement of SAIs. A ninth is to be screened and 15 more require family discussions to take place	M Haynes / M Corrigan / P Kingsnorth	20th October		In progress
6	SAI Reviews	Required: - Communications with service users / families who are subject to SAIs -will this initally be via phonecall or letter. Consideration of new SAIs and 5 previous. Letter for families drafted. - Discussion with DH to take place regarding progression of SAI's including discussions required with Trust staff, chair of MDM etc and ongoing family liaison arrangements. Meeting with Dermot Hughes, Melanie McClements and Maria O'Kane to take place this week	M Haynes / M Corrigan / P Kingsnorth		T:\AOB\Meeting 13.10.2020\ Letters to NOK T:\AOB\Meeting 13.10.2020\Letter advising of SAI	

6	Trust External Communications	Jane to speak to David DoH on coordinated Communications strategy. - Trust to decide on public communicaions arrangements - HSCB offered Comms manager support - Consideration of an embargoed realease to media on day of announcement - Is there a requirement to name the individual - DLS took a balanced view. GMC stated naming isnt usually the case. HROD linked in with Peter Watson regarding process that BHSCT followed, naming occured as a result of a media enquiry. DoH advised that Consultant name should be anonomised when making any statements/media releases, but recognised that as per the Belfast Trust it may go public via a different route	Martina, Patricia and Ronan	6th October		In progress
	Family Liaison	Family liaison person to be identified - MMcC has two persons who potentially can fulfil this role in mind. MMcC Discussions to take place with respective line managers to progress				
7	Additional Subject Matter Expertise	Further to this we have identified via RCS and BAUS another Subject Matter Expert Professor Krishna Sethia who is willing to engage with us.		20th October		In progress
8	Engagement of ISP to undertake waiting list work	Draft contract engagement document developed- pathways for service access are mapped. Documentation with contracts team for approval	M Haynes / M Corrigan	20th October	Document	In progress
9	Review Scope	*Action plan to review key areas of concern developed by Urology Team - Review of stent removals Jan 2019 - June 2020 160 pts - Review of elective activity Jan 2019 - June 2020 352 pts - Review of pathology results Jan 2019 August 2020 168 pts - Review of Radiology requests Jan 2019 - August 2020 1028 pts episodes - Review of MDM episodes Jan 2019 - July 2020 271 pts Initial concerns found in a review of 270 patients has found issues with clinical skills where deviations from guideline based treatments. There is a requirement to understand the volume of patients who may be in this group. Additional SME Consultant Urologist Krishna Sethia has been identified as another avialable subject matter expert.	M McClements / M Haynes / M Corrigan / R Carroll	1st September		In progress
10	Bicalutamide Concerns	PK provided an update on SAI independent expert who has stated that Bicalutamide management in at least one case likely contributed to the death of one service user. The group discussed actions required to ensure that patient safety is maintained. The group dicussed the challenge with identifying patients who have been prescribed by AOB and those that are prescribed in secondary care. An update is being sought from Tracey Boyce and Joe Brogan to identify prescribing patterns. Group agreed this required addressing as a matter of urgency No information recieved from the PHA / HSCB re primary care prescribed Bicalutamide	M McClements / R Carroll			
10	Clinician Early Alert	M O'Kane / S Wallace to discussed Clinician Early Alert with DoH. DoH advised that informal communication with other Trust MDs and HRODs would be appropriate. MOK has completed this action.	Dr Maria O'Kane / S Wallace	20th October		Complete

12	Communication with DoH / Minister	Group agreed that date of 19th October 2020 for release should be postponed. Group suggested MD communicates with CMO to ask to postpone date.	M O'Kane	14th October		
14	Telephone Support Service	Telephone Support Service developed. Attached Powerpoint	M McClements / R Carroll / M Corrigan / M Haynes	20th October		
16	Early Alert to DoH	Early Alert issued to DoH and HSCB regarding Bicalutamide	Dr Maria O'Kane / S Wallace	16th October		Complete
17	Information on Appraisal, Job Planning, Litigation and Complaints	Information on apprisal, job planning and complaints collated	S Wallace	7th August	Information Collated - saved in shared folder	Complete

Southern Health and Social Care Trust

Craigavon Area
Hospital
68 Lurgan Road
Portadown
BT63 5QQ

DATE OF LETTER

Patient Name
Address
Address
Address

Dear “NOK

Please accept my sincere condolences on the loss of >>>>>
It is with deep regret that I am writing to you to advise that the Trust has identified some concerns regarding the treatment and care provided to your>>>> when he was under the care of a Consultant Surgeon within the Southern Trust. This has led to a review of your xxxx’s care in the form of a level 3 Serious Adverse Incident review (SAI).

I recognise that receiving this letter may cause you and your family some distress and I am sorry for this. I would wish to assure you that we will do all that is possible to ensure that you are kept informed regarding this process and someone from the review team will be in touch with you as soon as possible to explain the SAI process. This review will be chaired by an Independent Chair who has not worked within the Southern Trust.

I have enclosed a patient information leaflet for information and contact details.

We also have a dedicated patient advice line for any questions you have in advance of your appointment. The number for the advice line is < INSERT DETAILS >

Once again, may I offer you my sincere apologies and assure you that we will do all that we can to ensure you receive the best possible care and treatment.

Yours sincerely,

Our Ref:

Private & Confidential

Mrxxx DATE
Xxxx
Xxxx

Dear Mr xx

I understand Mr Haynes has spoken with you in relation to the treatment and care you received by our Urology Service and that he advised you that the Trust would be reviewing the treatment and care you received through the Serious Adverse Incident (SAI) process. This SAI process will be part of a wider investigation involving a number of patients whose treatment and care will also be reviewed.

When the Trust is concerned that a patient has not received the treatment and care we expect, it is practice to commission a Serious Adverse Incident (SAI) of the care provided to ascertain if there were any lessons to be learned so that Trust services can be improved in the future. In order to have a degree of independence, the review is chaired by an external independent expert who does not work within the Southern Health and Social Care Trust.

The Chair of this review is Dr Dermot Hughes, retired Medical Director from the Western Heath and Social Care Trust. Dr Hughes would welcome a chance to engage with you or a family member nominated by you, to contribute to this review At that stage I will arrange, if you so wish, for the appropriate members of the review team to meet with you in order to discuss any issues or concerns you may have in relation to your care.

Alternatively if you would prefer to wait until the review is completed I will write to you again to offer the sharing of the draft report and provide you with an opportunity to comment on the report from the perspective of the family.

I hope you that you will consider giving the Trust an opportunity to gather all key information including your thoughts and comments. I have enclosed a guide for Service Users and their Family / Carers on the SAI process. If you would like to discuss the content of this letter, please do not hesitate to contact Mrs Patricia Kingsnorth on telephone no: Personal Information redacted by the USI or by emailing the Clinical and Social Care Governance Department on acute.governance@southerntrust.hscni.net.

Yours sincerely,

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: Personal Information redacted by the USI

ACUTE DIRECTORATE GOVERNANCE MEETING
ACTION NOTES

Date: Tuesday 4th June 2018 1:30 pm

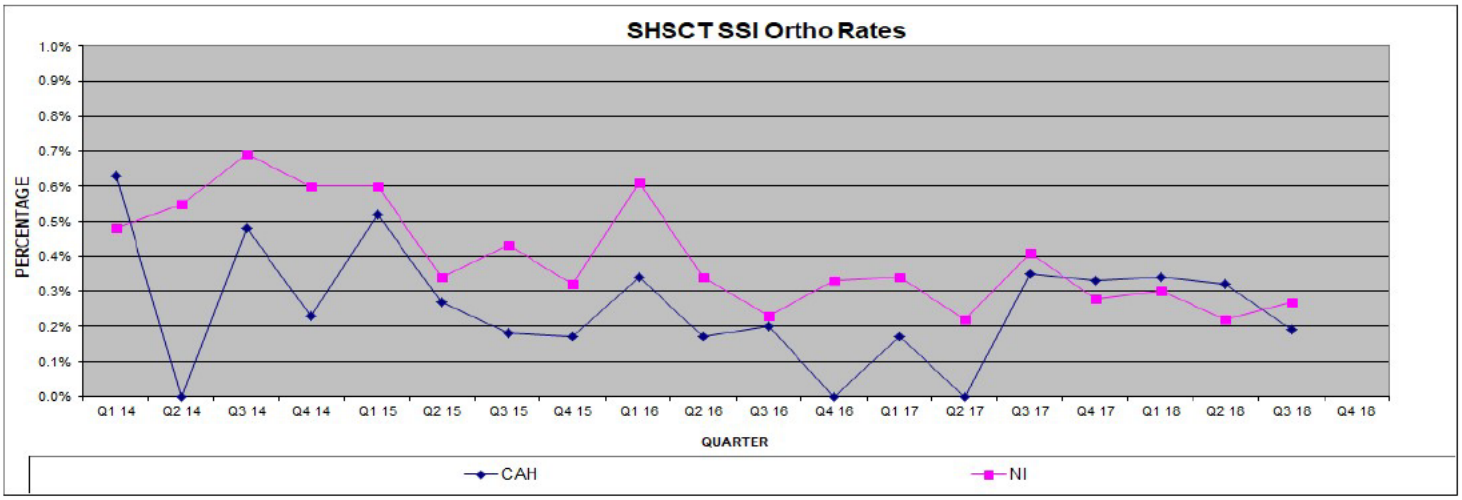
Venue: Meeting Room, Admin Floor, CAH,

1.0	**Apologies:** Esther Gishkori, Patricia Kingsnorth	**Action**
2.0	**Chair's Business** Catherine Weaver will be joining Acute Governance meeting at 1.30 pm to provide an awareness session around Freedom of Information requests that come in to Acute for response. **Catherine** outlined that Acute is only achieving 50% against the 20 day deadline. She explained the work ongoing with HOS and what we can do to improve this figure. If we don't hold information in a written down form (including emails) then we don't have to reply and we should go back to the FOI team to let them know this. If it is also going to have to take more than 2.5 days – then we also should be telling the FOI team this quickly. It is better to give some of the data before the 20 day deadline rather than wait for all the data and breach the 20 day target completely. Catherine is happy to come to any HOS meetings if needed – ADs to contact Catherine if needed.	**ADs**
3.0	**Patient Support Update** Acute Governance Report June19.doc **Audit report** 6) Clinical audit summary for Acute Cl	
4.0	**Complaints** April 2019 Acute SMT Governance Report.c	
5.0	**Directorate Risk Register**	

	• Directorate RR May19.xlsx; CCS Div.HOS.Team RR may19.xlsx; FSS Div.HOS.Team RR May19.xlsx; MUC Dir.Div.HOS.Team RR; SEC.ATICS Div.HOS.Team RR Ma	
6.0	absconding patients.xlsx **SAIs** • Summary report due to go the HSCB this month • Recommendations [redacted] Final 05 09 2018.docx; Action plan [redacted].docx; RCA level 2 [redacted] datix 94219.docx; Appendix 4 - SEA [redacted] docx	
7.0	**Medication Incidents** April 2019 Acute.xlsx	**Tracey Boyce**
8.0	**Implementation of learning** • Update from Divisions	**ADs**
9.0 SI	**Mandatory training compliance** CMT - Acute Compliance Report fo	**ADs**
10.0	**Any Other Business** • Effectiveness and Evaluation & Patient Safety • GAIN - Tracey reported that GAIN plan to do a discharge prescription audit. More info to follow. • Deprivation of liberty – Anne raised concerns about this coming into force for adults in October 2019. Anne asked Catherine about the possibility of a Trust wide working group to look at this and its implications for us, led by a Director. Barry reported that it is going to be discussed at next week's SMT.	
11.0	**Date of next meeting** The next Governance meeting will be held on Tuesday 2nd July 2019 at **1:30 pm** in the Meeting Room, Admin Floor, CAH	

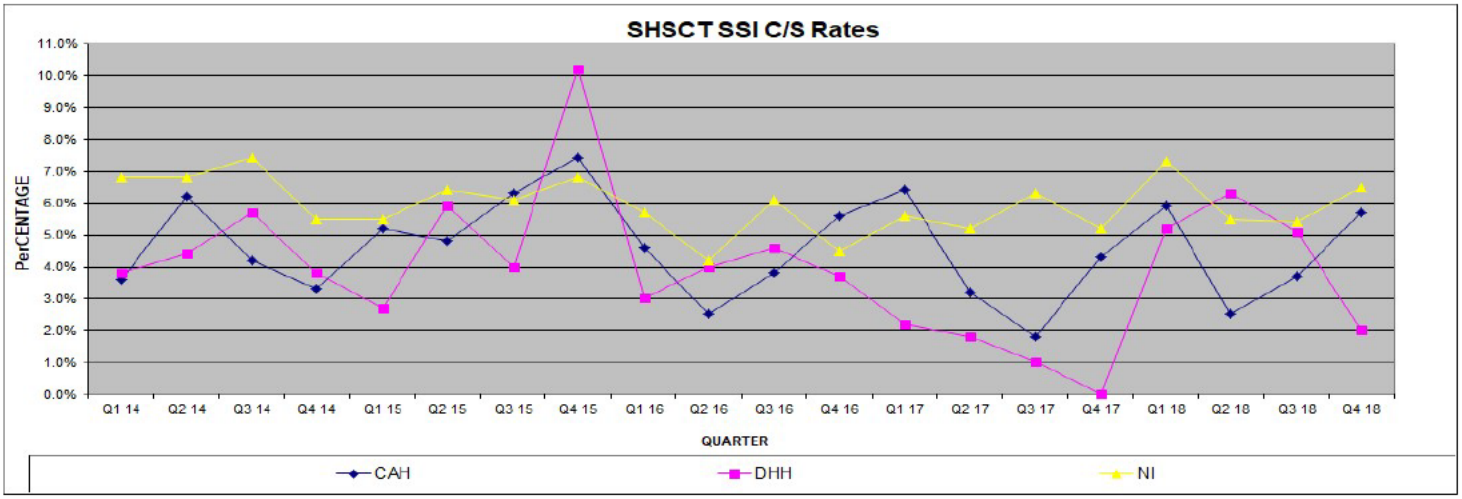
Patient Safety Report for Acute Governance Meeting June 2019

Surgical Site Infection (SSI) Ortho:



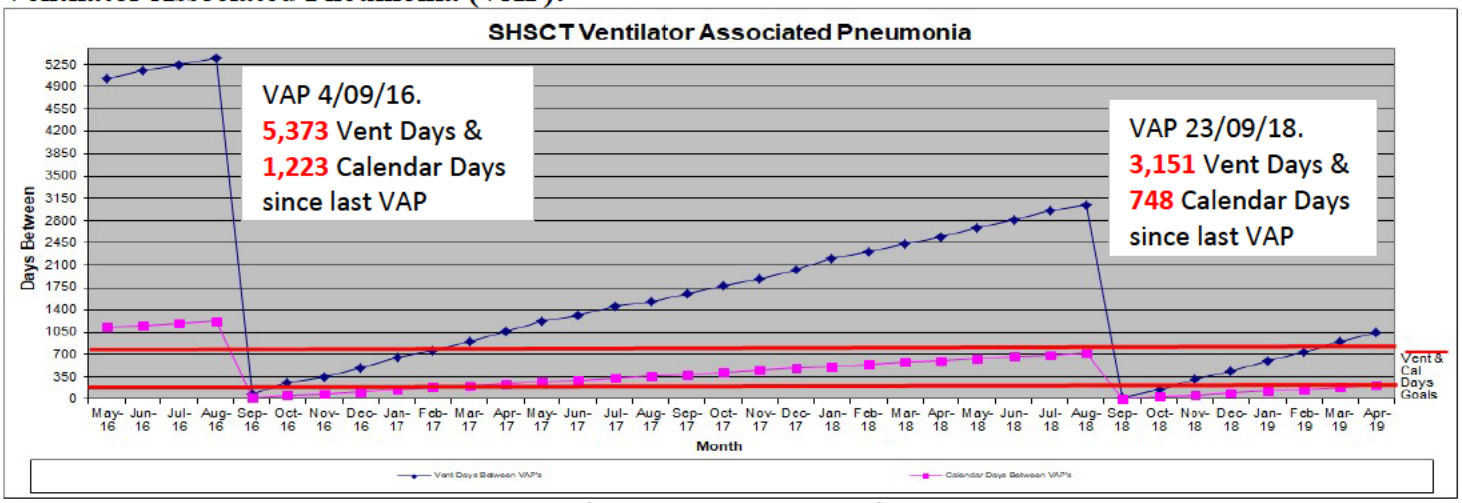
- Next update when Q4 2018 SSI Rates are released by the PHA

Surgical Site Infection (SSI) C/Section:



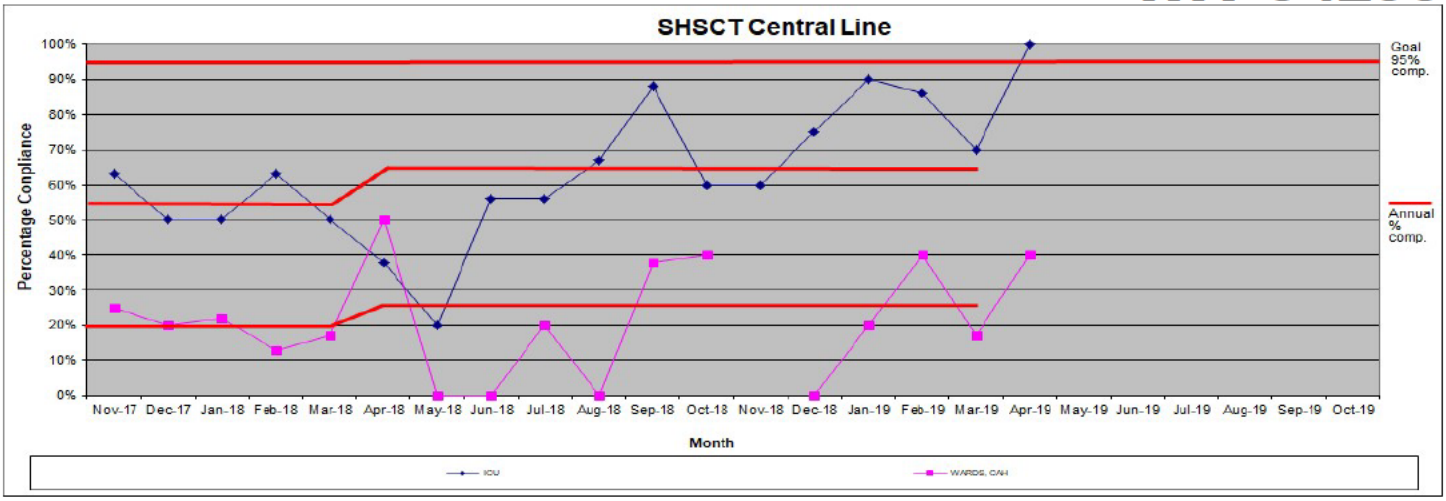
- Next update when Q1 2019 SSI Rates are released by the PHA
- The next quarterly Audits will take place in June 2019, with results reported in Aug 19

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **1039** (24th September 18 → 30th April 19)
- Calendar Days Between VAP's **219** (24th September 18 → 30th April 19)

Central Line:



Non-Compliant elements ICU:

- N/A **100%** Compliant (5/5 pts audited)

Non-Compliant elements Wards, CAH:

- In 1 of 5 cases audited the Central Line Insertion Record was not completed therefore there was no evidence of the method of Hand Hygiene, Skin Prep, type of Drape used or Site Selection
- In 1 of 5 cases audited the method of Hand Hygiene was inappropriate
- In 1 of 5 cases audited the jugular was used with no contrindication documented
- In 2 of 5 cases audited the Daily Review of the Line was not carried out. In both cases it was missed on only 1 day

- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

NEWS:

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 18/19	Q3 18/19	Q2 18/19	Q1 18/19
ACUTE	80% (430/532)	81% (430/532)	80% (419/522)	81% (288/355)
TRUST	83% (517/620)	84% (589/704)	81% (555/681)	81% (411/508)

- Next update in Aug 19 when Q1 19/20 data is available

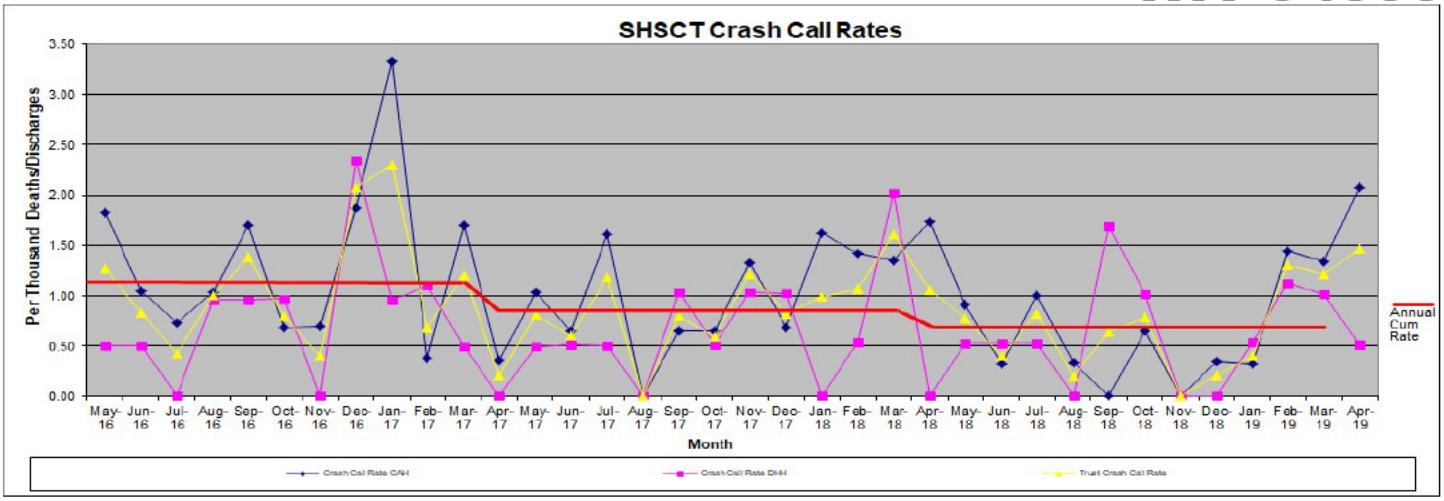
MUST (Malnutrition Universal Screening Tool):

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of compliance is below:

Quarter	Q4 18/19	Q3 18/19	Q2 18/19	Q1 18/19
ACUTE	91% (425/469)	86% (460/532)	88% (461/522)	87% (308/355)
TRUST	93% (575/620)	89% (626/704)	91% (617/681)	90% (457/508)

- Next update in Aug 19 when Q1 19/20 data is available

Crash Calls:



- CAH Rate **2.08** per 1,000 deaths/discharges (**6** Crash Calls) up from **1.34** (**4** Crash Calls) in Mar 19
- DHH Rate **0.52** per 1,000 deaths/discharges (**1** Crash Call) down from **1.01** (**2** Crash Calls) in Mar 19
- Trust Rate **1.46** per 1,000 deaths/discharges (**7** Crash Calls) up from **1.21** (**6** Crash Calls) in Mar 19
- Trust cumulative Crash Call rate for 19/20 was **1.46 (7)** per 1,000 deaths/discharges, up from **0.68 (38)** in 18/19

VTE:

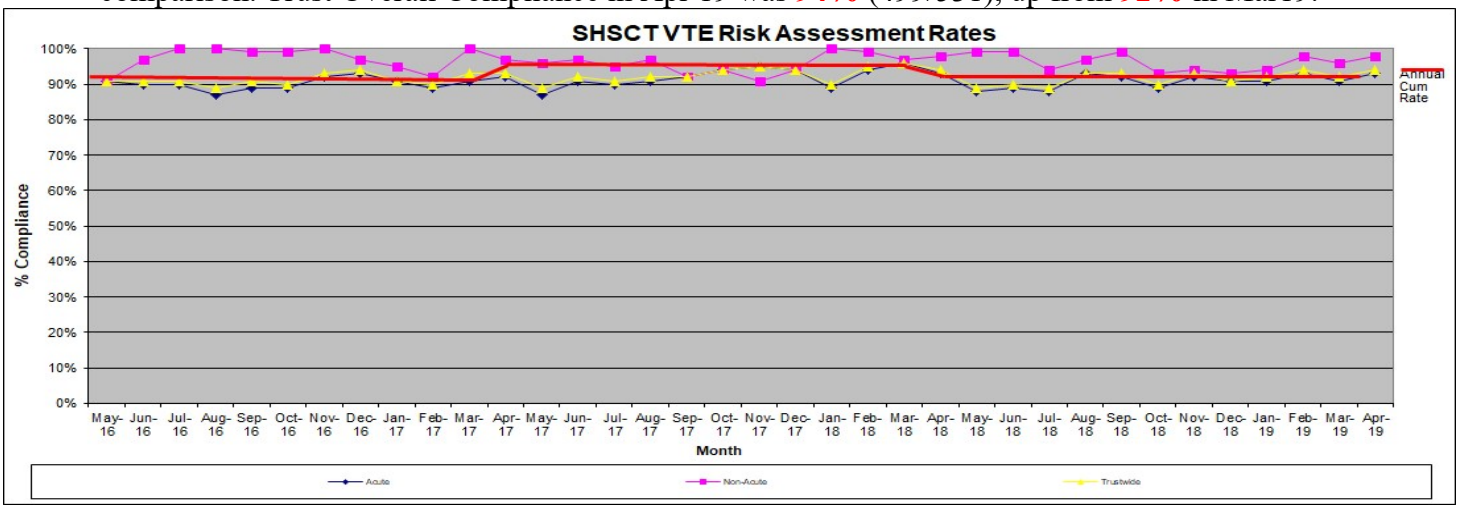
Apr 19 (Week Commencing 01/04/19 → Week Commencing 29/04/19)

Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 4 18/19 Percentage Compliance
S&EC	CAH	3 South	0	23	24	96% ↑	87% ↑
		4 North CESW	0	24	24	100% ↑	91% ↓
		4 South	1	19	20	95% ↑	93% ↑
		Elective Adm.	0	24	25	96% ↑	78% ↑
		Orthopaedic	0	24	24	100% ↔	98% ↔
		Trauma	0	23	24	96% ↓	100% ↑
	DHH	F/male Surg.	0	21	23	91% ↓	93% ↑
		MSW/HDU	0	23	23	100% ↑	93% ↓
M&UC	CAH	1 South	1	18	19	95% ↓	94% ↑
		1 North	0	23	25	92% ↑	91% ↑
		2 North Resp.	0	23	24	96% ↑	93% ↔
		Haematology	1	11	14	79% ↓	98% ↑
		2 South	1	16	17	94% ↓	90% ↓
		2 North Med.	0	22	24	92% ↓	98% ↔
		AMU	0	21	23	91% ↓	100% ↑
	DHH	F/male Med.	1	9	19	47% ↓	79% ↔
		CCC/MMW	0	24	24	100% ↑	97% ↓
		Stroke/Rehab	0	24	25	96% ↑	80% ↓
IMWH	CAH	Gynae	0	23	24	96% ↑	96% ↑
TOTAL			**5 ↓ (6)**	**395**	**425**	**92.9% ↑**	**91.8% ↑**

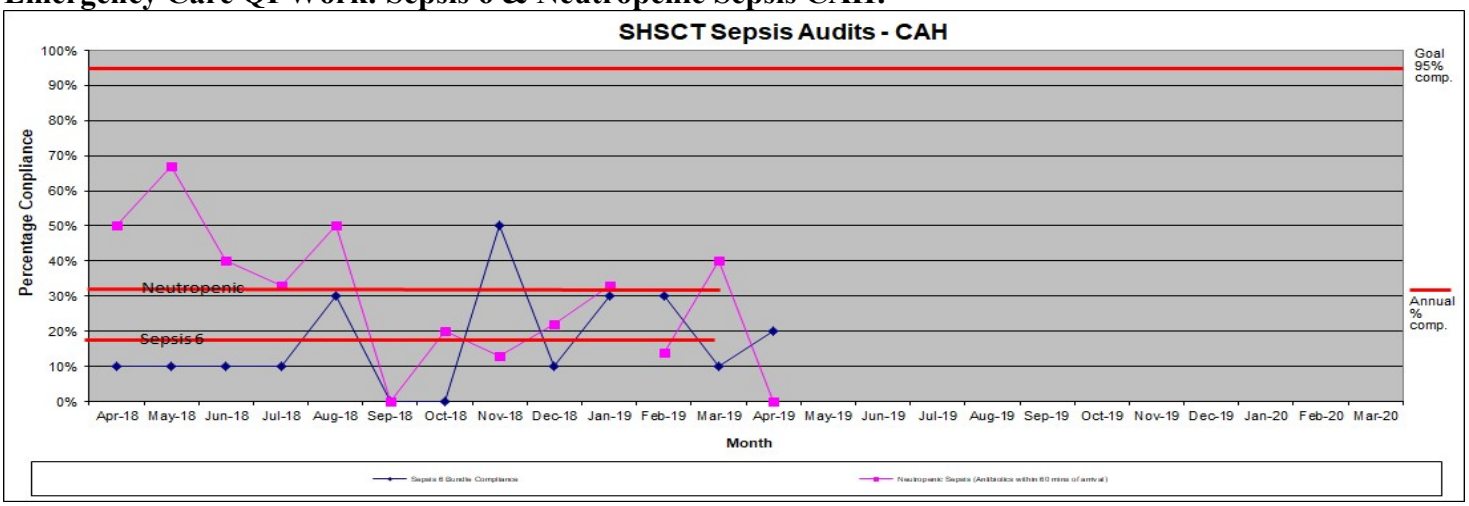
Key: Red – Under 85% compliance, Amber – Compliance between 85% & 94%, Green – Above 95% (Reg. target)

- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **92.9%** (395/425 charts audited) up from **91.1%** (307/337 charts audited) in Mar19.
- Total number of weekly audits not completed in Mar 19 was **5** down from **6** in Mar 19

- The Run Chart below shows compliance against the Commissioning Plan target of 95% compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in Apr 19 was **94%** (499/531), up from **92%** in Mar19.

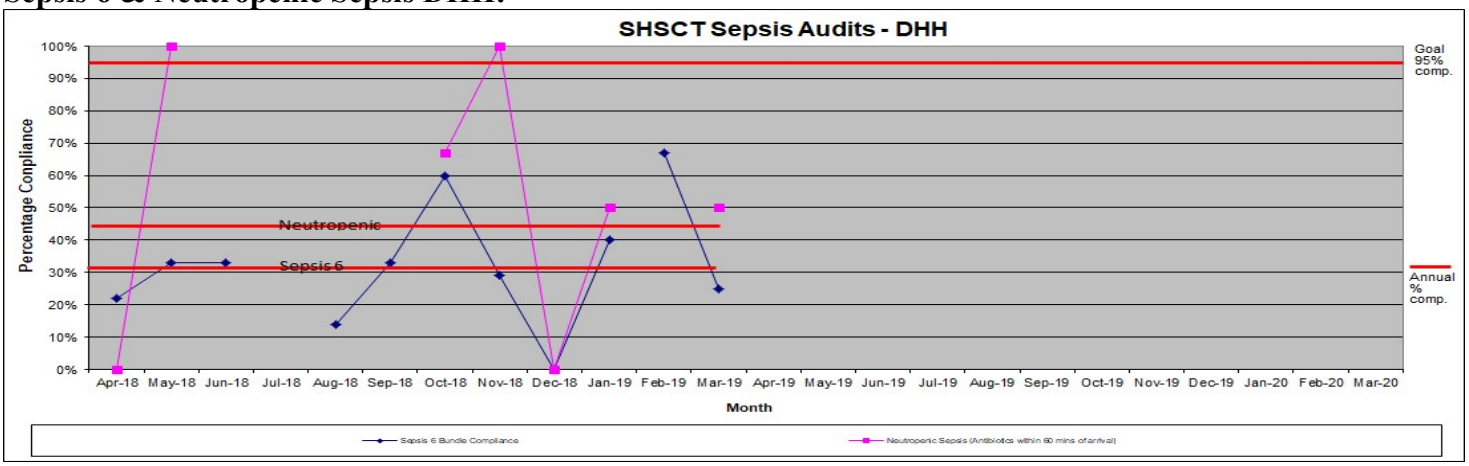


Emergency Care QI Work: Sepsis 6 & Neutropenic Sepsis CAH:



- The above Run Chart shows the percentage of neutropenic sepsis patients who received antibiotics within 60 minutes of arrival at ED & those patients who are suspected of sepsis on arrival to ED
- From Apr 19 there is no longer a requirement to forward the results of the Neutropenic Audit to the Health & Social Care Board
- Summary of April 19 Audit - The time dependent elements of the Sepsis 6 Bundle i.e. IV Fluids & IV Antibiotics continue to prove challenging. Although all 10 patients did receive IV Fluids & IV Antibiotics only 2 received IV Fluids within an hour of arrival & only 3 received IV Antibiotics within an hour of arrival. The other element where compliance remains low is the recording of Urinary Output

Sepsis 6 & Neutropenic Sepsis DHH:



- Neutropenic Sepsis Audits for February & April 19 not received at time of reporting
- Sepsis6 Audit for Apr 19 has been received but yet to be validated
- Summary of March 19 Audit - The time dependent elements of the Sepsis 6 Bundle i.e. IV Fluids & IV Antibiotics continue to prove challenging, although compliance figures are slightly better that those at CAH.
- Results shared with Lead Clinician & Lead Nurse for this QI work to address areas of non-compliance

Critical Medicines Omitted:

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of compliance is below:

Quarter	Q4 18/19	Q3 18/19	Q2 18/19	Q1 18/19
ACUTE	5 (469)	3 (532)	9 (522)	2 (355)
TRUST	6 (620)	5 (704)	9 (681)	2 (508)

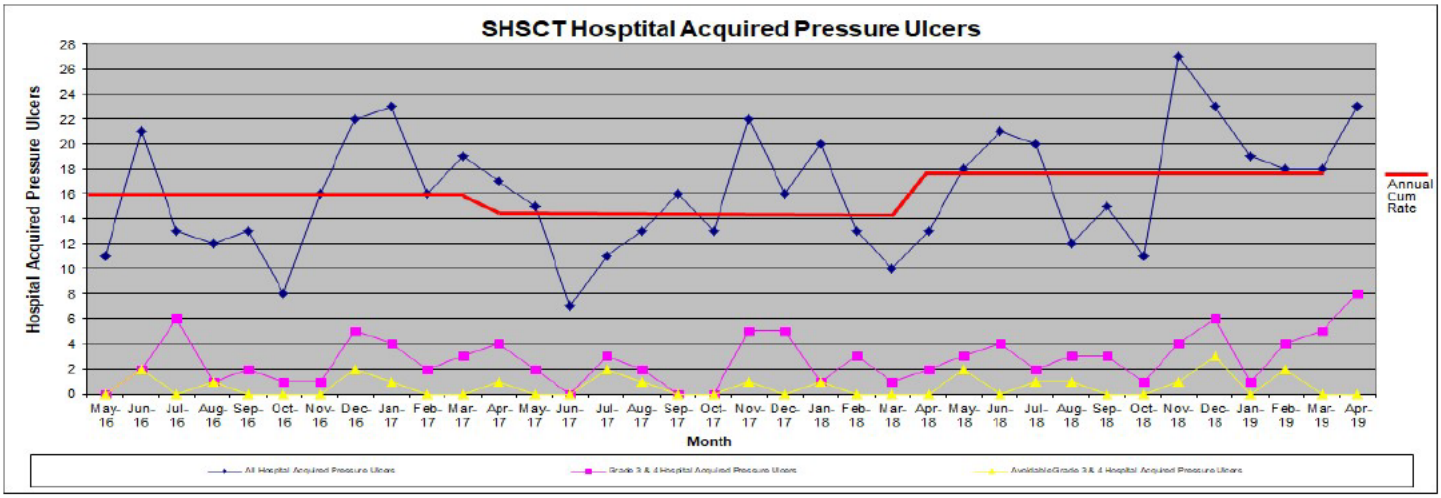
- Next update in Aug 19 when Q1 19/20 data is available

SKIN Care (Pressure Ulcer):

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 18/19	Q3 18/19	Q2 18/19	Q1 18/19
ACUTE	74% (165/122)	70% (201/288)	71% (172/242)	56% (60/107)
TRUST	82% (295/361)	78% (338/435)	79% (293/372)	63% (122/195)

- Next update in Aug 19 when Q1 19/20 data is available



- There were 23 Hospital Acquired Pressures reported in Apr 19. Of these 8 were Grade 3/4 Ward Acquired Pressure Ulcers, (1 South, 1 North, 3 South, 4 South & Trauma, 4 South, CAH, HDU, DHH and Wards 1 & 2 Lurgan). To date an RCA has been carried out in 1 case & was deemed unavoidable. RCA's will be undertaken in the remainder of these cases in due course
- In 18/19 to date RCA's have been carried out on 35 cases with 10 deemed to have been avoidable. This represents 5.2% of all Ward Acquired Pressure Ulcers reported in 18/19

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2019/20:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 19/20	Rate & No 18/19
CAH															
Ward 4 South	1												1	0.93	0.62 (8) ↑
Ward 4 North	1												1	1.06	0.81 (9) ↑
Ward 3 South	2												2	2.17	0.48 (6) ↑
Trauma Ward	3												3	4.04	3.13 (28) ↑
Orthopaedic Ward	0												0	0	0 (0) ↔
Gynae Ward	0												0	0	0.58 (2) ↓
ICU	1												1	4.93	10.10(24) ↓
Ward 2 South Medicine	0												0	0	2.62 (16) ↓
Ward 2 South Stroke	0												0	0	1.82 (11) ↓
Ward 2 North	0												0	0	0.72 (9) ↓
Ward 5 Haematology	1												1	2.91	1.79 (8) ↑
Ward 1 South	2												2	1.88	1.31 (17) ↑
Ward 1 North	1												1	1.05	0.79 (9) ↑
AMU	0												0	0	0.70 (8) ↓
Rec/Renal/2 West/WinterW	2												2	N/A	N/A
DHH															
Male Surgical	0												0	0	0.17 (1) ↓
Female Surg/Gynae	0												0	0	0.79 (7) ↓
HDU	1												1	3.62	1.23 (4) ↑
Stroke/Rehab	0												0	0	0.19 (2) ↓
Male Med/CCU	0												0	0	0 (0) ↔
Female Medical	0												0	0	0.85 (10) ↓
Lurgan															
Ward 1	2												2	4.34	0.18 (1) ↑
Ward 2	1												1	2.04	1.64 (10) ↑
Ward 3	1												1	2.04	0.68 (4) ↑
STH															
Ward 1 STH	3												3	6.07	0.64 (4) ↑
Ward 2 STH	1												1	1.98	0.49 (3) ↑
MHLD															
Gillis	0												0	0	0.45 (3) ↓
Willows	0												0	0	0.29 (2) ↓
TOTAL	23												23		
RATE	1.25													1.25	0.98 (215)↑

- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for Apr 19, based on **29** Wards was **1.25** (**23**/18,352) per 1,000 Occupied Bed Days up from **0.95 (18)** per 1,000 Bed Days in Mar 19.

- The Trust's 2018/19 Hospital Acquired Pressure Ulcer Rate, based on **29** Wards was **0.98 (215)** per 1,000 Bed Days, compared to **0.80 (173)** in 2017/18.

Maternity Quality Improvement Collaborative:

- Awaiting update from Wendy Clarke & Patricia Kingsnorth

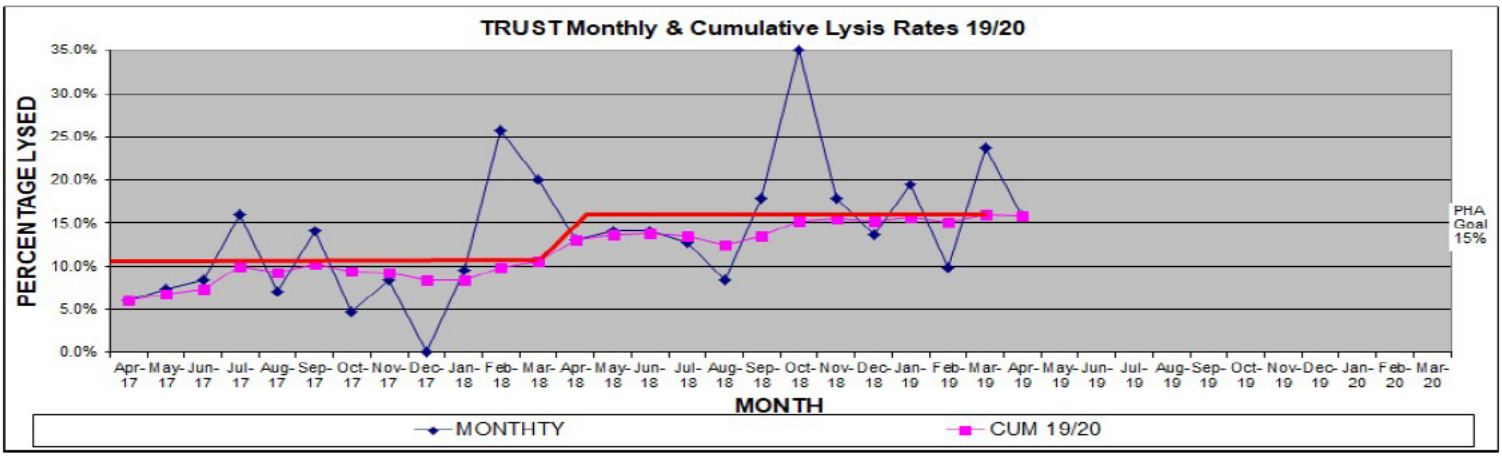
WHO Surgical Safety Checklist:

- The Monthly Audits were reinstated in Apr 19. The results of same will be reported next month

Stroke Collaborative:

- Regional agreement to collect data on the following, however only Lysis Data will be reported to the PHA/DHSSPS on a quarterly basis:

	CAH		DHH		TRUST		
Measure		Apr 19		Apr 19		Apr 19	Commentary Apr 19
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	17/18 98% 18/19 99%	100% (60/60)	17/18 99% 18/19 99%	100% (18/18)	17/18 99% 18/19 99%	100% (78/78)	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	17/18 96% 18/19 99%	100% (19/19)	17/18 95% 18/19 98%	100% (8/8)	17/18 96% 18/19 99%	100% (27/27)	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	17/18 59% 18/19 90%	40% (2/5)	17/18 88% 18/19 75%	100% (1/1)	17/18 68% 18/19 86%	50% (3/6)	CAH: In 2 of the 3 cases the target timeframe was missed by only 1 min. In the 3rd case the patient presented out-of-hours. Outside target timeframe by 25 mins. Reason for delay not recorded
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	17/18 91% 18/19 4%	100% (5/5)	17/18 100% 18/19 89%	100% (1/1)	17/18 94% 18/19 93%	100% (6/6)	-
	CAH		**DHH**		**TRUST**		**AIM 19/20 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration is at least (% to be confirmed)**
Outcome Measure	**2018/19**	**Apr 19**	**2017/18**	**Apr 19**	**2017/18**	**Apr 19**	
Monthly Thrombolysis Rate		17.2% (5/29)		11.1% (1/9)		15.8% (6/38)	
Thrombolysis Rate (Yearly)	16.3% (49/301)	17.2% (5/29)	14.9% (20/134)	11.1% (1/9)	15.9% (69/435)	15.8% (6/38)	



- The above is "Real Time" data, which is subject to change. The Directorate of Performance & Reform is responsible for reporting to the RHSCB. From the above table only the lysis rates are reported. Furthermore their report is 3 months in arrears to allow Clinical Coding to reach an acceptable level.

Patient Falls:

- During 2017/18 the figures released to the PHA were those from the Independent Audit undertaken by the Lead Nurses. However during 2018/19 the figures released will be a combination of the Independent Audit & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q4 18/19	Q3 18/19	Q2 18/19	Q1 18/19
Acute Bundle A Compliance	72% (339/469)	76% (402/532)	71% (370/522)	60% (213/355)
Trust Bundle A Compliance	78% (481/620)	80% (563/704)	75% (514/681)	68% (344/508)

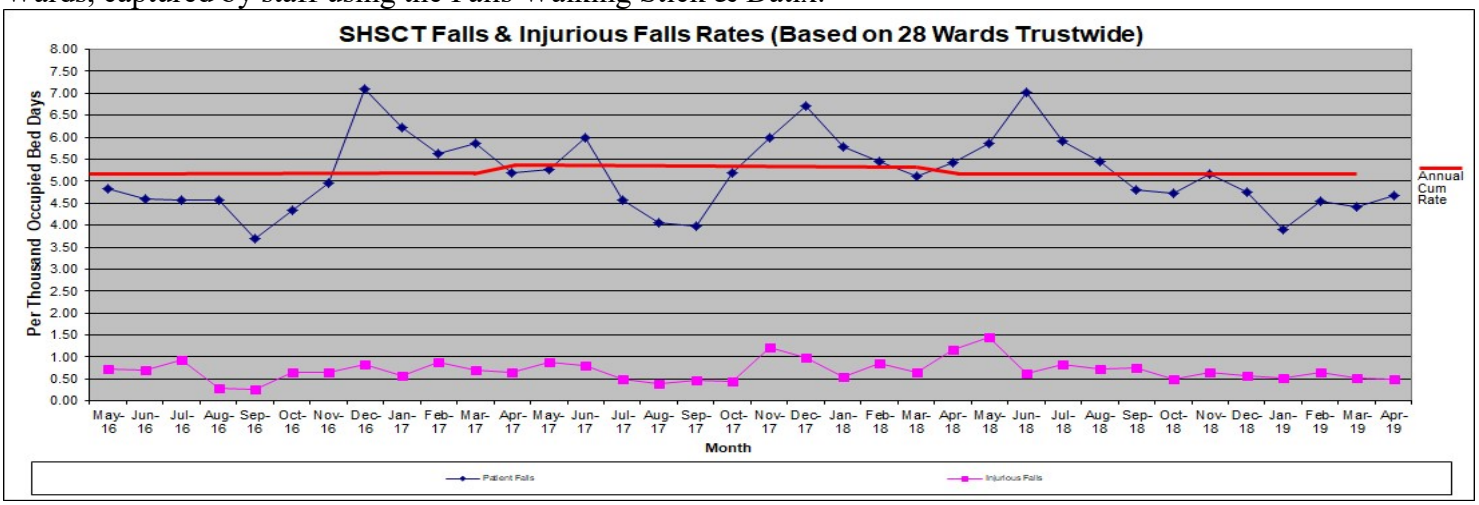
Quarter	Q4 18/19	Q3 18/19	Q2 18/19	Q1 18/19
Acute Bundle B Compliance	70% (252/361)	69% (295/426)	48% (186/388)	51% (122/240)
Trust Bundle B Compliance	76% (390/511)	74% (438/591)	58% (306/532)	62% (238/385)

- Next update in Aug 19 when Q1 19/20 data is available

The table below gives details of individual Ward's Falls Numbers & Falls Rate 18/19:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 19/20	Rate 18/19
CAH															
Ward 4 South	5												5	4.65	2.72 (35) ↑
Ward 4 North	1												1	1.06	4.33 (48) ↓
Ward 3 South	1												1	1.08	3.30 (41) ↓
Trauma Ward	3												3	4.04	5.26 (47) ↓
Orthopaedic Ward	1												1	3.14	4.55 (21) ↓
Gynae Ward	0												0	0	2.60 (9) ↓
Ward 2 South Medicine	5												5	9.90	8.53 (52) ↑
Ward 2 South Stroke	4												4	7.77	6.29 (38) ↑
Ward 2 North	4												4	3.86	4.96 (62) ↓
Haematology Ward	4												4	11.63	2.90 (13) ↑
Ward 1 South	7												7	6.59	5.18 (67) ↑
Ward 1 North	2												2	2.11	3.59 (41) ↓
AMU	12												12	12.12	7.82 (89) ↑
3 North Winter Ward	5												5	N/A	3.31 (7)
DHH															
Male Surgical	2												2	4.17	4.14 (25) ↑
Female Surg/Gynae	0												0	0	3.82 (34) ↓
HDU	3												3	10.87	2.46 (8) ↑
Stroke/Rehab	4												4	4.71	5.22 (55) ↓
Male Med/CCU	4												4	4.04	4.41 (52) ↓
Female Medical	7												7	7.01	5.08 (60) ↑
Lurgan															
Ward 1	1												1	2.17	5.23 (29) ↓
Ward 2	0												0	0	4.27 (26) ↓
Ward 3	1												1	2.04	2.57 (15) ↓
STH															
Ward 1 STH	2												2	4.05	1.93 (12) ↑
Ward 2 STH	1												1	1.98	2.44 (15) ↓
MHLD															
Gillis	3												3	6.00	16.32 (108) ↓
Willows	3												3	4.92	15.86 (108) ↓
TOTAL	85												85		
RATE	4.68													4.68	5.16 (1117) ↓

The Run Chart below shows Patient Falls & Injurious Falls Rates per 1,000 Occupied Bed Days, based on 28 Wards, captured by staff using the Falls Walking Stick & Datix.

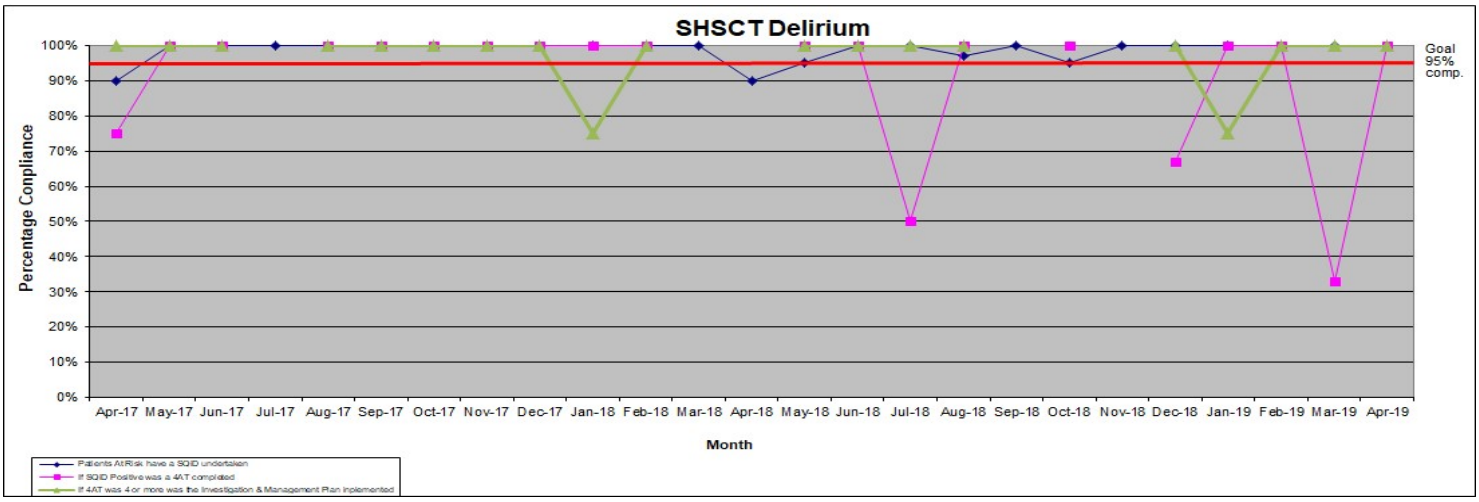


- Falls Rate **4.68** (**85**/18,149 Occupied Bed Days) up from **4.41** (**83**/18,815) in Mar 19
- Injurious Falls Rate **0.50** (**9**/18,149 Occupied Bed Days) down from **0.53** (**10**/18,815) in Mar 19
- Cumulative Falls Rate 18/19 was **5.16**, compared to **5.28** in 2017/18.

Regional Delirium Audit:

- Three measures are in place to demonstrate progress in the use of the Delirium Tool:
  - **Number of at risk patients who have a SQiD (single question in delirium) carried out**
  - **Number of patients with a 4AT completed (tool to assess for delirium)**
  - **Number of patients with an investigations & management plan completed**

The Run Chart below shows the progress with each of the above elements on the Trauma Ward, CAH



- Non-Compliant elements:
  - N/A
- Audits commenced on Ward 2 South, CAH on Feb 19
- Delirium QI work spread to Stroke/Rehab DHH & will then be introduced to Female Medical ward. These wards will commence auditing of the Delirium Bundle in due course

Southern Health and Social Care Trust

Clinical Audit Summary Report to Acute Directorate Clinical Governance Meeting, 4th June 2019

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate
1	IV Fluids in children and Young People:	ADs		Continuous	ATICS cases aged 14-15 years, who have received perioperative IV fluids, are not included in the audit from this time. Overall 42 cases have been reviewed from 1/2/18 – 5/5/19 as below. Overall compliance is 19%. All 9 Indicators have compliance < 95%. No additional cases for April 2019.  Acute Directorate February 2018 onwa  2. Acute Directorate summary of results 1s
2	Clinical Audit work programme 2018/2019, Acute Directorate	All	Operational teams		Directorate's clinical audit work programme 2018/19, 2019/20 attached.  Database Clinical Audit Acute 2018 201
3	HQIP 2019/2020 list for consideration	All	Operational teams		HQIP Quality Accounts list 2019-20 for validation by clinical teams. Awaiting feedback on outstanding audits regarding SHSCT participation.  HQIP Quality Accounts list 2019-20
4	Participation in the National Cardiac Arrest Audit (NCCA) 2019/20	All	Operational teams		The Trust are currently unable to participate in the National Cardiac Arrest Audit (NCAA) 2019/20 due to GDPR issues however the Trust have paid to participate in this audit. There is no date regarding when GDPR issues will be resolved. At the Acute Resuscitation Committee meeting on 15/4/19 it was agreed to not participate in the national audit however continue with the local audit.

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate
5	NCEPOD Long Term Ventilation study	All	Mr McArdle, R Haffey		Clinical questionnaire requested by NCEPOD submitted. Organisational questionnaires (Adult services > 18 years old) for Craigavon Area Hospital and Daisy Hill Hospital submitted.
6	NCEPOD Acute Bowel Obstruction study	All	Mr McArdle R Haffey	31/5/19 Clinician questionnaires 31/5/19 Organisational questionnaires	Case note extracts of CAH cases and DHH requested by NCEPOD have been forwarded to NCEPOD. Four Clinician questionnaires to be completed (CAH n=2, DHH n= 2). Three questionnaires have been submitted. One outstanding CAH clinician questionnaire to be submitted by 31/5/19 as per NCEPOD. Organisational questionnaires requested by NCEPOD for Craigavon Area Hospital and Daisy Hill Hospital. Organisational questionnaire for Daisy Hill Hospital completed by Mr McArdle and requires final approval to submit. Organisational questionnaire for Craigavon Area Hospital is outstanding.
7	NCEPOD Dysphagia in people with Parkinson's Disease study	All	Mr McArdle R Haffey	TBA	NCEPOD are undertaking a study to look at the care of patients with Parkinson's Disease (PD) who are admitted to hospital when acutely unwell. NCEPOD are currently finalising the study protocol and data collection period and will make this available on their website as soon as it is ready. Scoping for this study has been undertaken as below. In the interim, NCEPOD are trying to gain an understanding of the number of patients which could be included in this study. NCEPOD have requested the number of patients using the following criteria: 1) How many patients were admitted to your hospital with an ICD10 code for Parkinson's disease recorded in any position between 1st June 2018 – 31st December 2018 inclusive (G20; G21) 2) Approximately how many of the above patients were admitted electively 3) Approximately how many of the above patients were admitted as an emergency This information has been shared with NCEPOD.

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate
8	NCEPOD hospital management of out of hospital cardiac arrests	All	Mr McArdle R Haffey	14/6/19	Case identification stage: NCEPOD have requested a list off all patients aged 16 and over who had an out of hospital cardiac arrest AND who achieved return of spontaneous circulation (ROSC) during the study time period 1st January 2018 (00:00) and 31st December 2018 (23:59). Exclusions for this study include: 1 - Patients under the age of 16, 2 - Cases where the patient's admission is due to drowning, drug overdose or poisoning 3 - Cardiac arrest occurring during inter-hospital transfer or on acute NHS hospital trust premises Data being collated and will require approval to submit to NCEPOD.
9	National Audit of Community Acquired Pneumonia (CAP) from British Thoracic Society (BTS)	Mrs McVey	Dr R Convery , Dr L Polley	31/5/19	The aim of the BTS audit programme is to drive improvements in the quality of care and services provided for patients with respiratory conditions across the UK. Audit period: 1 December 2018 – 31 January 2019. Data entry period: 1 December 2018 – 31 May 2019. The 2018/19 audit has two parts: **Part 1: Main adult CAP audit –** one record per patient. **Part 2: Organisational audit –** one record to be submitted by each participating site to provide information on the audit process for the Trust. Issue with clinical coding backlog to identify patients. 3 month back-log for data is being escalated to the Acute Risk Register. Data data submitted by Dr Polley.
10	Adult Non Invasive Ventilation (NIV) Audit from British Thoracic Society (BTS)	Mrs McVey	Dr R Convery , Dr L Polley	30/6/19	Data collection period is 1 February 2019 – 31 March 2019.
11	**Adult Smoking Cessation Audit** from British Thoracic Society (BTS)				Audit period is 1 Jul 2019 – 31 Aug 2019. Data entry deadline is 31/10/19.
12	REspiratory COmplications after abdomiNal surgery (RECON): A student-led observational prospective audit of postoperative pulmonary complications after major abdominal surgery		Mr Epanomeritakis, Mr R Brown, Ivan Kwek	16/5/19	STARSurg is a national student led collaborative network involved in this national audit which involves General Surgery, Urology, Gynaecology and Anaesthetics. Proposed time period for data capture is 21/2/19 – 17/4/18. Data to be submitted by 16/5/19. Approval for Trust participation in this national audit has been given by Associate Medical Directors and Assistant Directors.

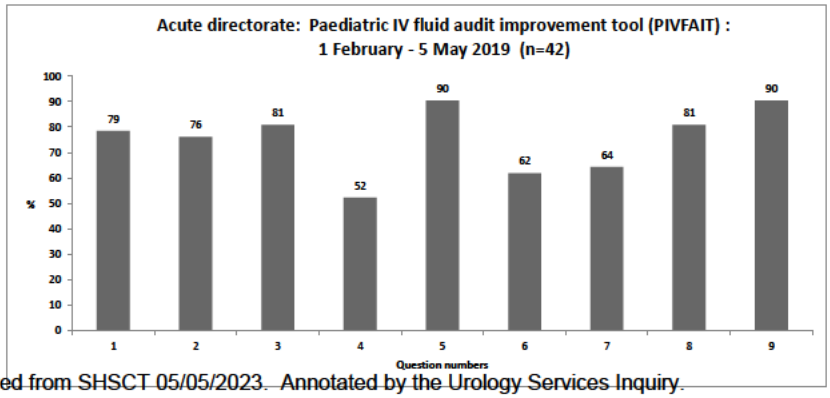
	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate
13	Sentinel Stroke National Audit Programme (SSNAP) Acute Organisational Audit	Noeleen Lambe	Dr McCaffrey CAH Dr McGleenon DHH	To be advised	Registration for the audit has been submitted for Craigavon Area Hospital and Daisy Hill Hospital. Organisational audit to commence on 3/6/19.
14	National End of Life Audit (NACEL)	Mr B Conway	Mr D Calvin	30/6/19	Audit methodology: All adult deaths (18 plus). • 20 consecutive deaths audited from first 2 weeks in April and 20 consecutive deaths from first 2 weeks in May (DHH and CAH). • 40 deaths from whole of April and May (STH and LGH) All sudden deaths and all deaths that occurred within 4 hrs of admission are excluded. Meeting planned for 4/6/19 to discuss how the audit progresses.
15	Audits that link to Standards and Guidelines				 S&G audit.xlsx
16	Clinical guidelines	All	Operational teams		Please provide feedback regarding the Operational Divisional arrangements for reviewing clinical guidelines which are nearing, or have expired their review date. Follow on from discussion at the Acute Governance meeting 7/8/18 by Anne Quinn.
17	Internal review of Morbidity and Mortality (M&M) 2018-2019				BSO are undertaking a regional audit on the implementation of the Regional Mortality and Morbidity Reporting System (RM&MRS). Internal audit team to report their findings to the Trust.
18	Regional Morbidity and Mortality Review System (RM&MRS)				Roll-out of the changes to RM&MRS has been undertaken on 10/1/19. The attached information has been forwarded to M&M Chairs and Sub speciality Chairs.   Final RM&MRS Changes Document f RMMRS Changes to benefit users.docx
19	MCCD book - contingency arrangements for death certification when RM&MRS is down	All	Operational teams		The MCCD booklets are now stored on the Patient flow office, in both CAH &DHH and Sister office Ward 1, Lurgan Hospital. These booklets are for only for use in as a contingency when the NIECR system is down. A communication from the Medical Director's office has been shared regarding this matter.

	Audit topic	Directorate contact	Clinical audit lead	Deadline	Proposed areas for discussion and action within Acute Directorate
20	Morbidity and Mortality meetings	All			• Issues around videoconferencing have arisen. Meeting undertaken with IT to discuss. • Difficulty for new Locum appointments completing death certificate on NIECR. These new appointments require to be added to their respective M&M team on NIECR. M&M facilitators to be advised of new starts.
21	Emergency Department clinical audit meeting	Mrs McVey	Dr Mawhinney		First meeting held on 18/4/19. Next meeting on 12/6/19.

Paediatric Intravenous Fluid Audit Implementation Tool

Child

	Date	1/2/18 - 5/5/19				Ward/Dept	Acute						
Q	1	2	3	4	5	6	7	8	9				
	Patient identification	Glucose Monitoring		Cumulative input and output totalling and fluid balance.	Patient weight	DFBC calculation guidance completed.		Electrolyte monitoring	12 hour assessment.				
	Are ALL the following patient identifiers provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number	While the child is receiving IV fluids, is there a Blood Glucose result recorded on the DFBC, (in accordance with the 2017 Paediatric Therapy Wallchart) i.e. at least 12 hourly?	Were ALL Blood Glucose measurements greater than 3mmol/L? If answer = No; Enter Hospital Number of those below 3mmol/L for Trust audit dept. to check for treatment.	Are ALL of the following amounts (in mls) recorded on the DFBC? 1. Oral/IV amounts, (all administered types of intake to be recorded). 2. Day and night totals. 3. Grand Total IN 4. Grand Total OUT 5. 24 hour Fluid Balance	Is there a patient weight in kgs, given on the DFBC?	Are the appropriate calculation guidance sections for the IV therapy completed?	Are there coded indications for the fluid administration provided?	Is there an E&U result recorded on the DFBC, (in accordance with the 2017 Paediatric Therapy Wallchart)?	When IV fluids are administered for longer than 12 hours. is there a 12 hour Reassessment box* appropriately completed on the DFBC with an answer to the question: Is the infusion prescription still suitable - followed by a doctors signature? * Can be 10 - 14 hours	Compliance %	Division	Ward	Month
Name or Number	Record Yes = 1 , No = 0 (the only possible entries are either a 1 or a 0)												
Personal Information redacted by the USI	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH	Feb-18
	1	1	1	0	0	0	1	1	1	67	ATICS	Theatre CAH	Feb-18
	1	1	1	0	1	0	0	1	1	67	ATICS	Theatre CAH	Feb-18
	0	1	1	1	1	0	1	1	1	78	ATICS	Theatre CAH	Apr-18
	1	1	1	0	1	0	1	1	1	78	ATICS	Theatre CAH	May-18
	1	1	1	0	1	1	1	1	1	89	S&EC	4 North	Feb-18
	0	1	1	1	1	1	1	1	0	78	S&EC	4 North	Feb-18
	1	1	1	1	1	1	1	1	0	89	S&EC	4 North	Feb-18
	1	1	1	0	1	1	0	1	0	67	S&EC	4 North	Apr-18
	1	1	1	0	1	1	1	1	1	89	M&UC	FMW	Mar-18
	0	0	1	0	1	1	0	1	1	56	M&UC	AMU	Apr-18
	1	0	0	0	1	1	0	1	1	56	M&UC	ED CAH	Mar-18
	1	1	1	1	1	1	1	1	1	100	M&UC	ED DHH	Mar-18
	1	1	1	0	1	1	1	1	1	89	M&UC	ED CAH	Apr-18
	1	0	0	0	1	0	0	0	1	33	M&UC	ED CAH	Apr-18
	1	1	1	1	1	1	1	1	1	100	M&UC	ED CAH	May-18
	1	1	1	0	1	1	0	1	1	78	M&UC	ED DHH	May-18
	0	0	0	0	0	0	0	0	1	11	S&EC	3 South	Mar-18
	1	1	1	1	1	1	1	1	1	100	ATICS	Theatre CAH	Aug-18
	0	0	1	1	1	1	0	0	1	56	ATICS	ICU	Sep-18
	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH	Oct-18
	1	1	1	0	0	1	0	1	1	67	ATICS	Theatre CAH	Oct-18
	0	0	0	0	0	0	0	0	0	0	ATICS	ICU	May-18
	1	1	1	0	1	0	1	1	1	78	ATICS	Theatre CAH	Jul-18
	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH	Aug-18
	1	1	1	1	1	0	1	1	1	89	ATICS	Theatre CAH	Aug-18
	1	1	1	1	1	1	1	1	1	100	M&UC	ED DHH	Sep-18
	0	1	1	1	1	1	1	1	1	89	ATICS	Theatre DHH	Aug-18
	1	0	0	0	1	0	1	0	1	44	M&UC	ED CAH	Aug-18
	0	1	1	1	1	1	0	1	1	78	M&UC	ED CAH	Sep-18
	1	1	1	1	1	0	0	1	1	78	ATICS	DSU CAH	Aug-18
	1	1	1	0	1	1	1	1	1	89	M&UC	ED CAH	Oct-18
	1	1	1	0	1	0	1	1	1	78	ATICS	Theatre CAH	Oct-18
	1	1	1	1	1	1	1	1	1	100	M&UC	ED DHH	Aug-18
	0	1	1	0	1	1	0	1	1	67	M&UC	ED CAH	Nov-18
	1	1	1	1	1	1	1	1	1	100	M&UC	ED CAH	Nov-18
	1	0	0	1	1	1	1	0	1	67	M&UC	ED CAH	Dec-18
	1	1	1	1	1	1	1	1	1	100	M&UC	ED CAH	Mar-19
	1	0	0	1	1	0	1	0	1	56	M&UC	ED CAH	Mar-19
	1	0	0	0	1	1	0	0	1	44	M&UC	ED DHH	Feb-19
	1	1	1	1	1	1	0	1	1	89	ATICS	Theatre DHH	Jan-19
	1	1	1	1	1	1	1	1	1	100	M&UC	ED CAH	May-19
	Total Audits = Obs =		42	Paediatric Version V0.13 July 2016			Total number fully Compliant = Com =			8			
Number of Charts completed	42	42	42	42	42	42	42	42	42				
Number of compliant cases	33	32	34	22	38	26	27	34	38				
	79	76	81	52	90	62	64	81	90				



Total number of charts completed	42
Total fully compliant	8

Overall fully compliant
19%

Acute directorate: Paediatric IV fluid audit improvement tool (PIVFAIT) Results 1st February 2018- 5th May 2019

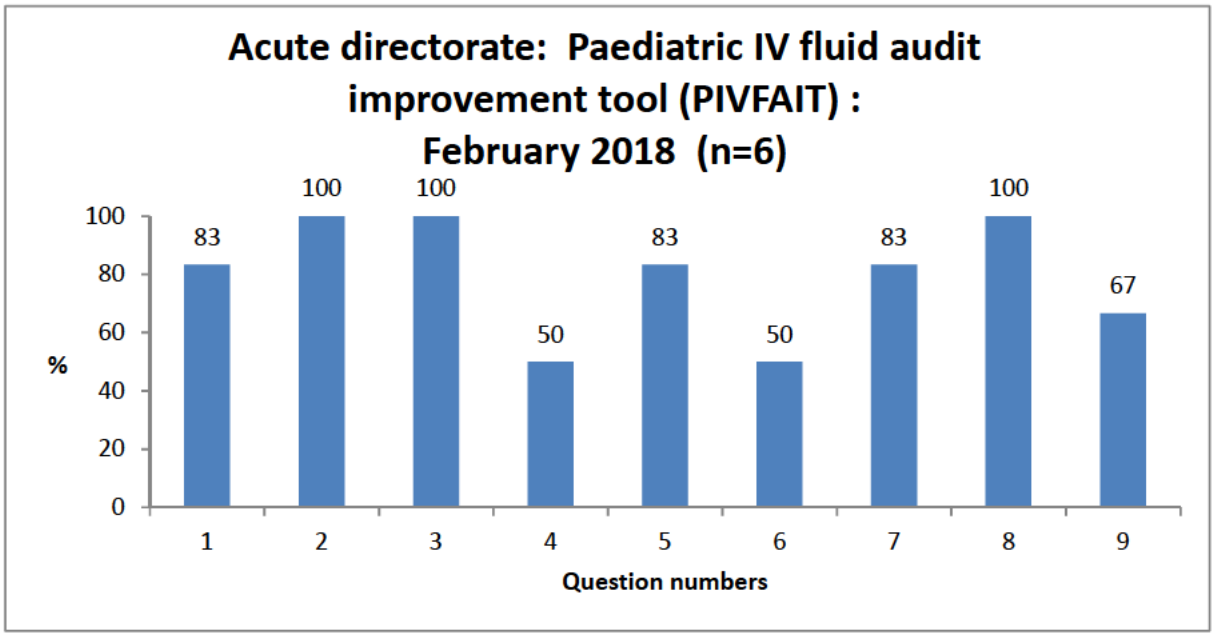
The Acute Directorate Paediatric IV Fluid Audit Improvement Tool (PIVFAIT) assesses 9 indicators / questions for all patients aged 14-15 who received IV fluids during their hospital admission.

The 9 indicators / questions are:

Indicator / Question		Details
1	**Patient identification**	Are ALL the following **patient identifiers** provided on both sides of the DFBC? 1. Full Name 2. Date of birth 3. Hospital number
2	**Glucose Monitoring**	While the child is receiving IV fluids, is there a **Blood Glucose result** recorded on the DFBC (in accordance with the 2017 Paediatric Therapy Wallchart) i.e. at least 12 hourly?
3		Were ALL **Blood Glucose** measurements greater than 3mmol/L? If answer = No; Enter Hospital Number of those below 3mmol/L for Trust audit dept. to check for treatment.
4	**Cumulative input and output totalling and fluid balance.**	Are ALL of the following amounts (in mls) recorded on the DFBC? 1. Oral/IV amounts, (all administered types of intake to be recorded). 2. Day and night totals. 3. Grand Total IN 4. Grand Total OUT 5. 24 hour Fluid Balance
5	**Patient weight**	Is there a patient weight in kgs, given on the DFBC?
6	**DFBC calculation guidance completed.**	Are the appropriate calculation guidance sections for the IV therapy completed?
7		Are there coded indications for the fluid administration provided?
8	**Electrolyte monitoring**	Is there an E&U result recorded on the DFBC, (in accordance with the 2017 Paediatric Therapy Wallchart)?
9	**12 hour assessment.**	When IV fluids are administered for longer than 12 hours. Is there a 12 hour Reassessment box* appropriately completed on the DFBC with an answer to the question: Is the infusion prescription still suitable - followed by a doctors signature? * Can be 10 - 14 hours .

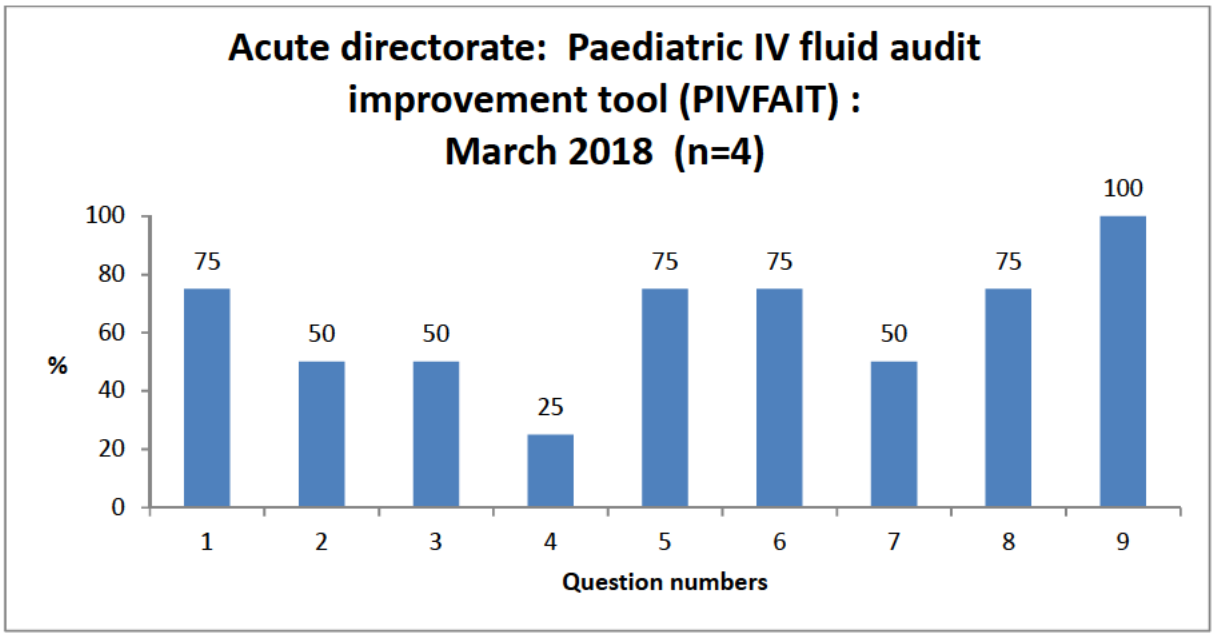
Monthly audit Results: % compliance against 9 questions

February 2018 (n=6)



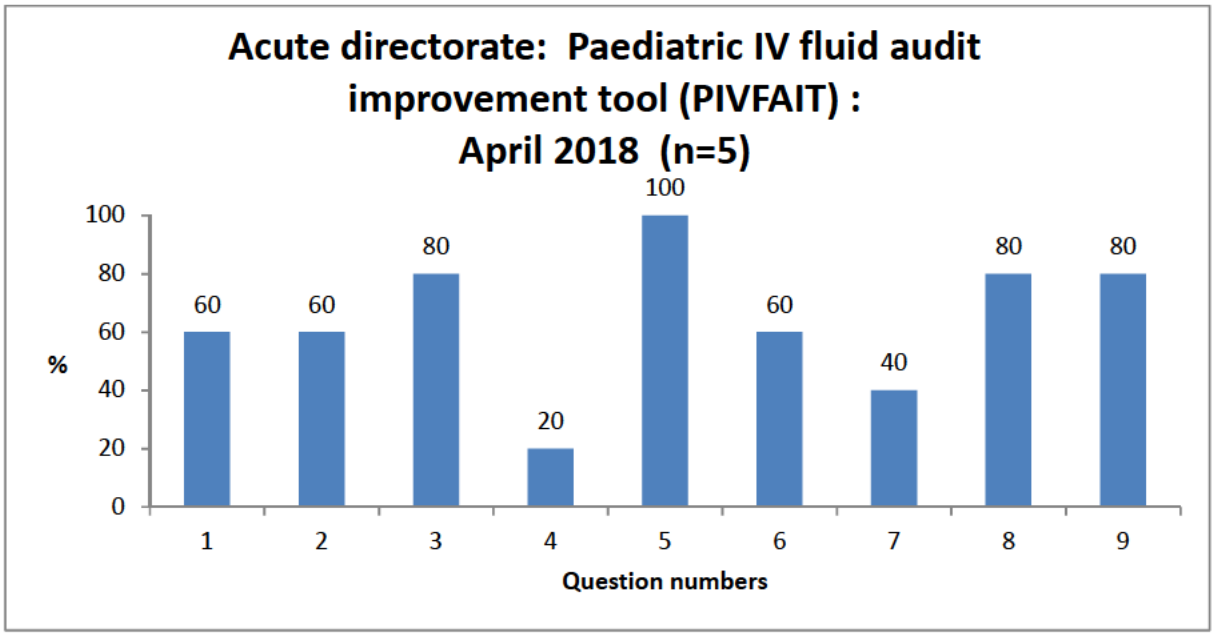
All 9 questions met: 0/6 cases = 0%.

March 2018 (n=4)



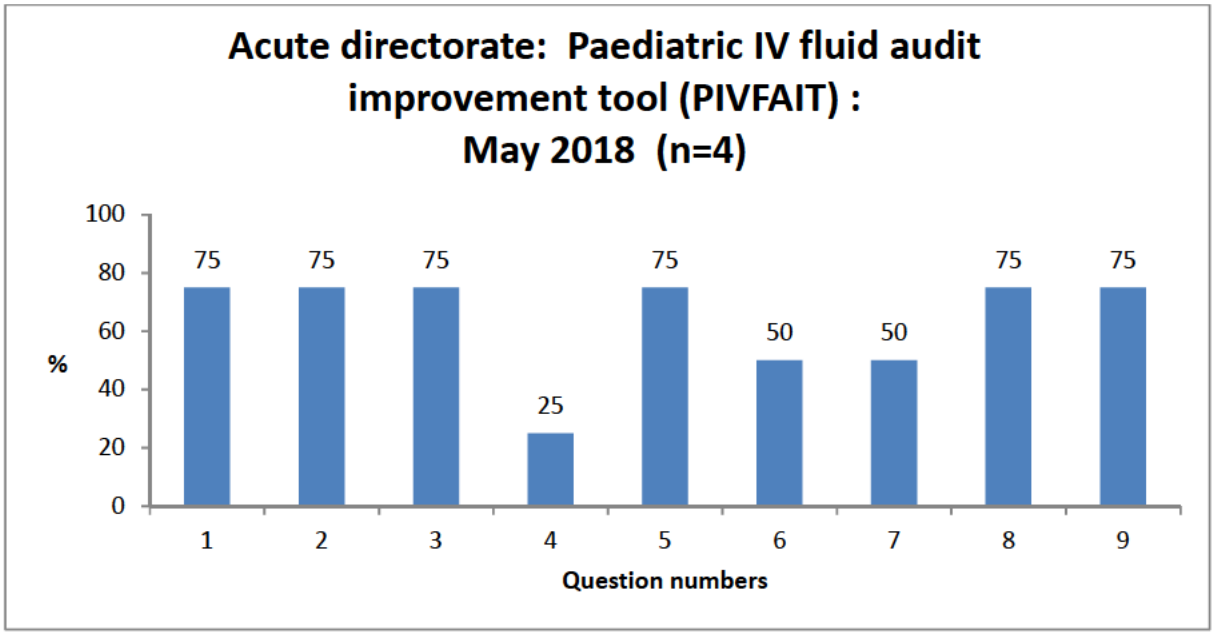
All 9 questions met: 1/4 cases =25%.

April 2018 (n=5)



All 9 questions met: 0/5 cases = 0%.

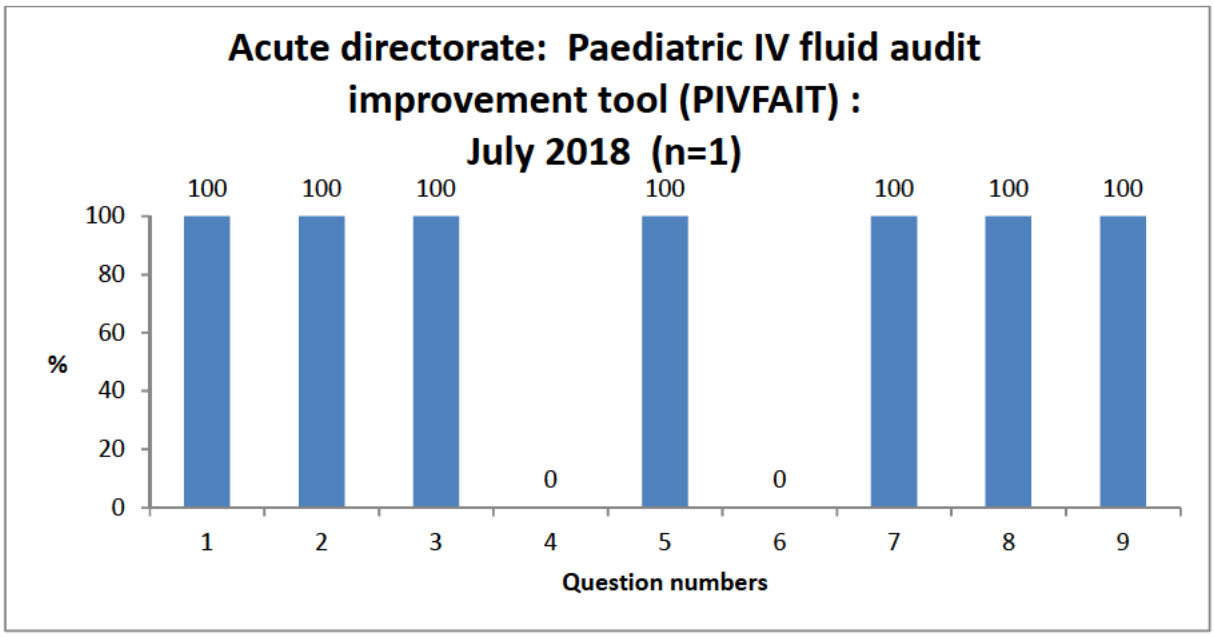
May 2018 (n=4)



All 9 questions met: 1/4 cases = 25%.

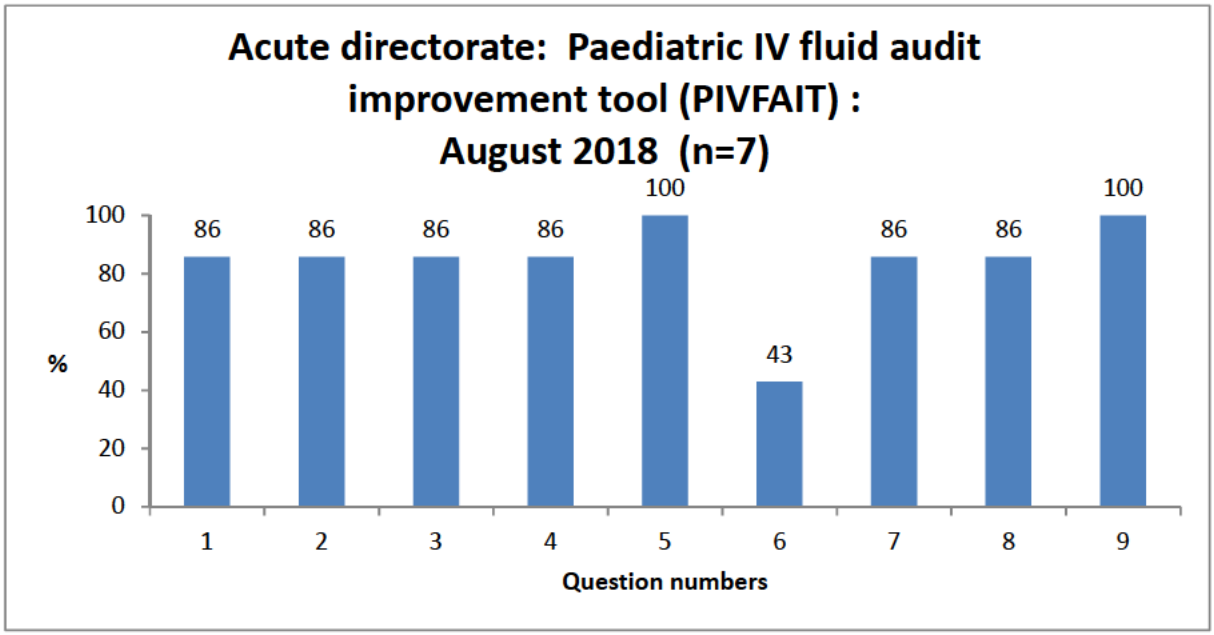
June 2018 – there were no applicable cases for audit.

July 2018 (n=1)



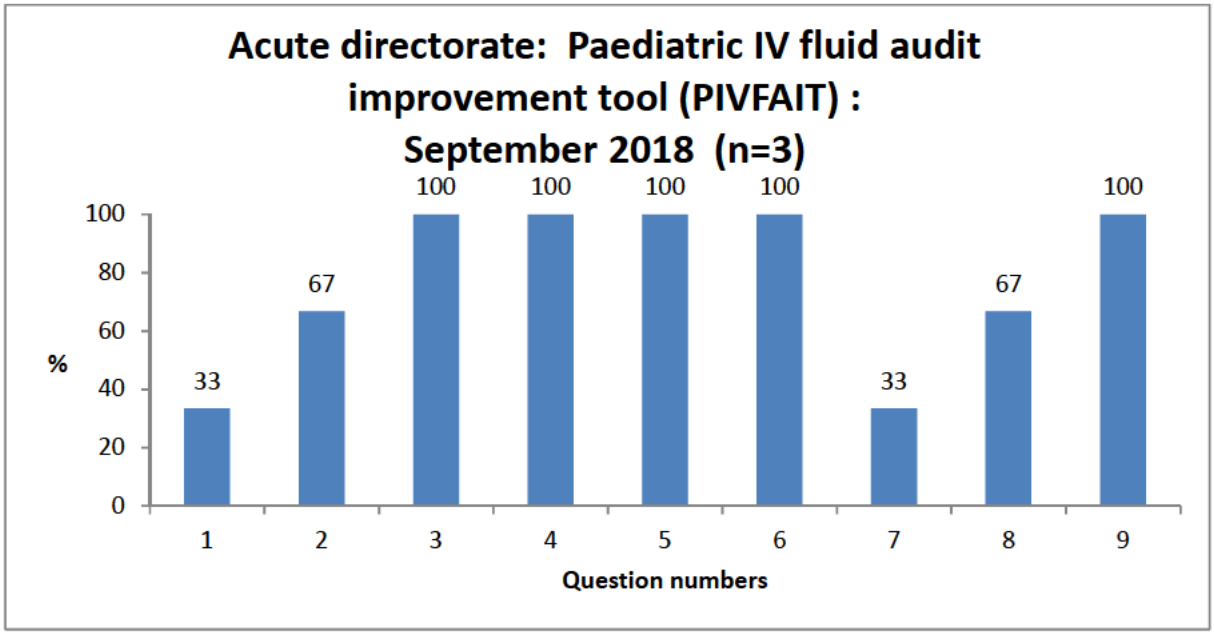
All 9 questions met: 0/1 cases = 0%.

August 2018 (n=7)



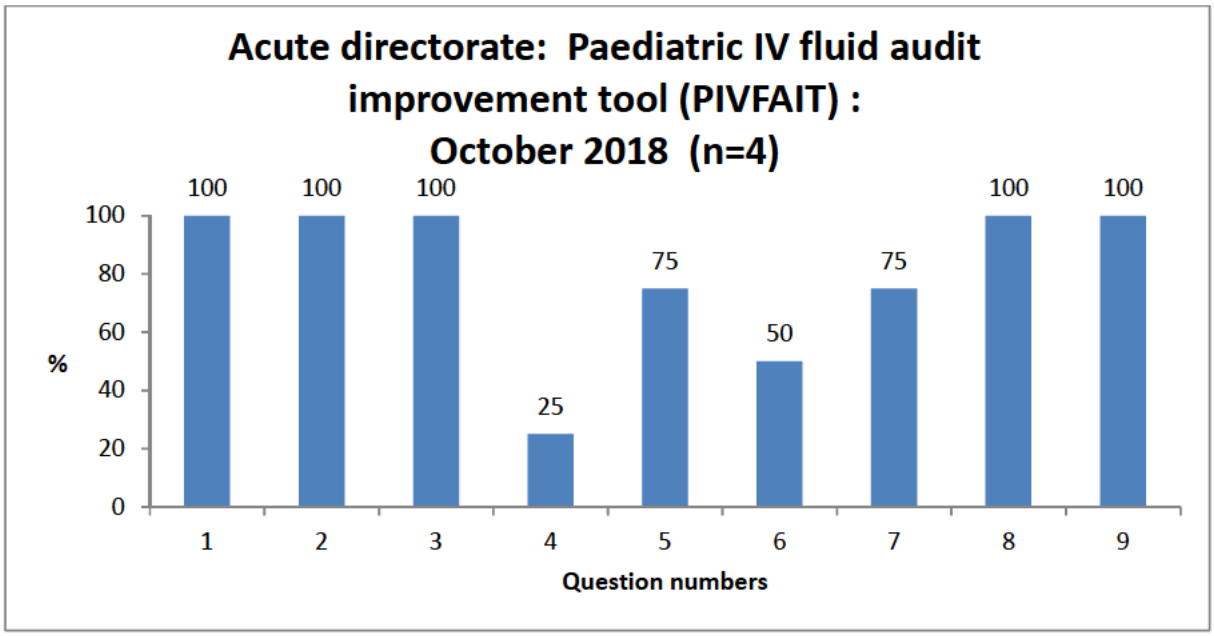
All 9 questions met: 2/7 cases = 29%.

September 2018 (n=3)



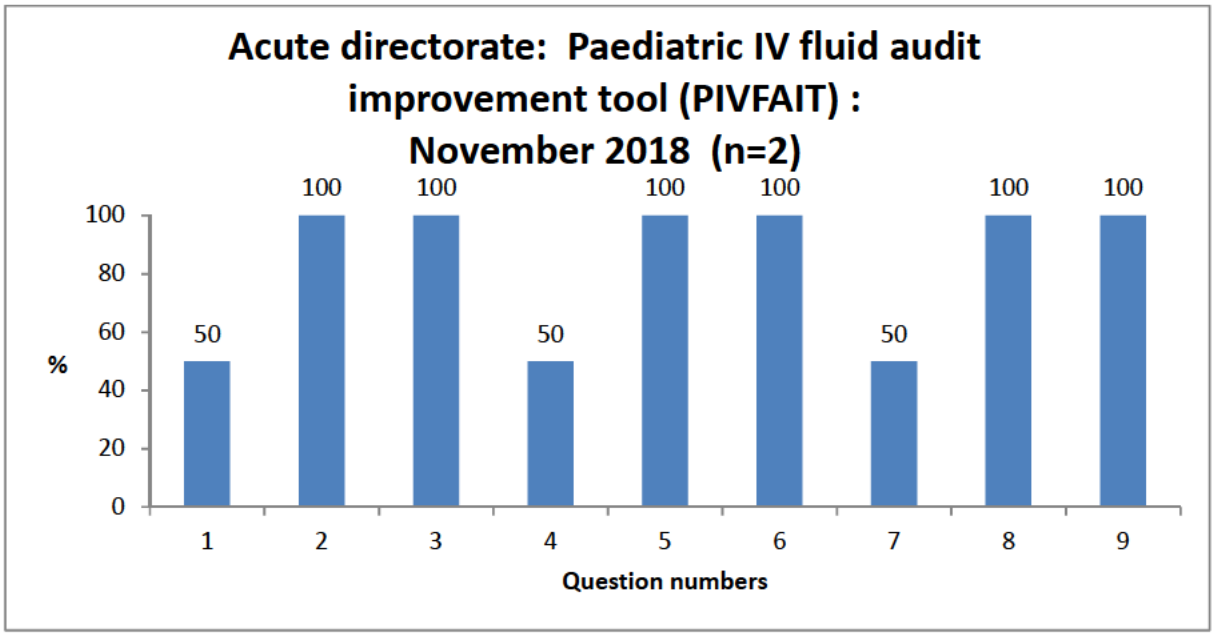
All 9 questions met: 1/3 cases = 33%.

October 2018 (n=4)



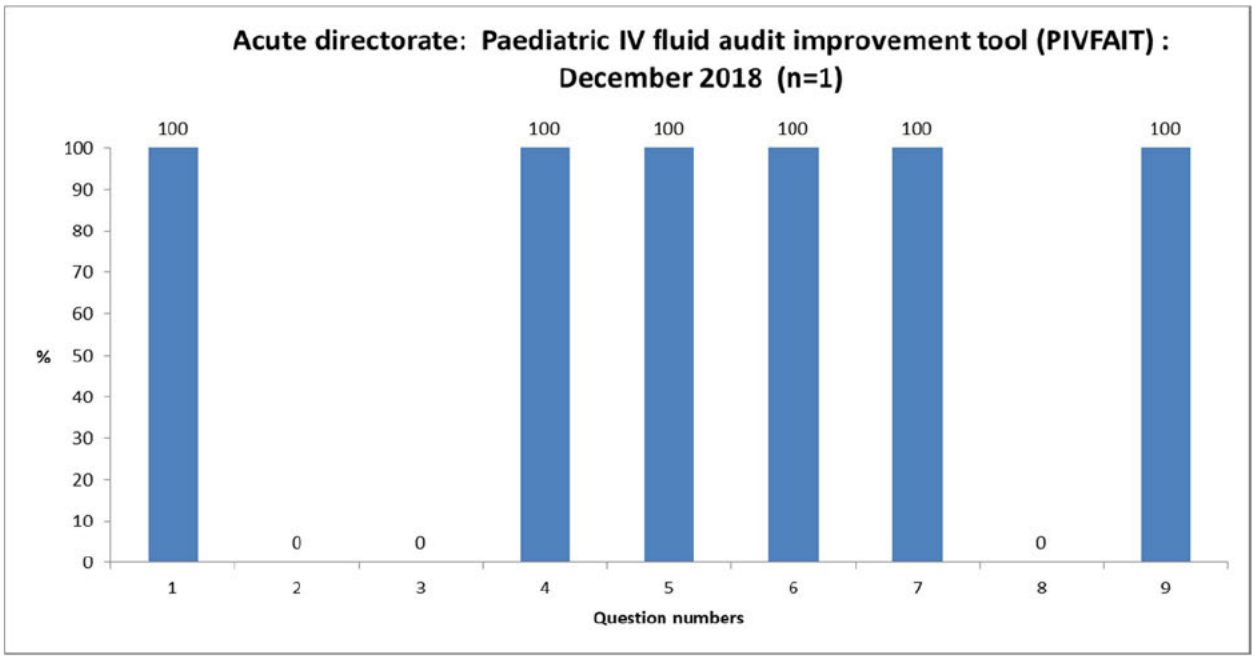
All 9 questions met: 0/4 cases = 0%.

November 2018 (n=2)



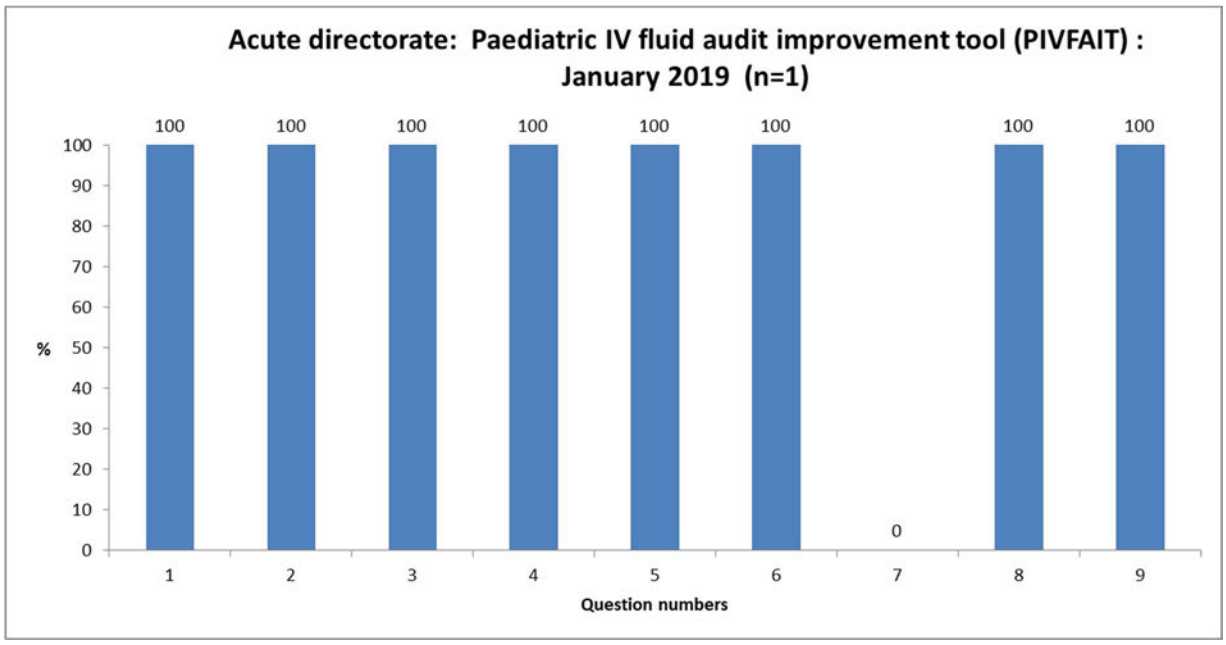
All 9 questions met: 1/2 cases = 50%.

December 2018 (n=1)



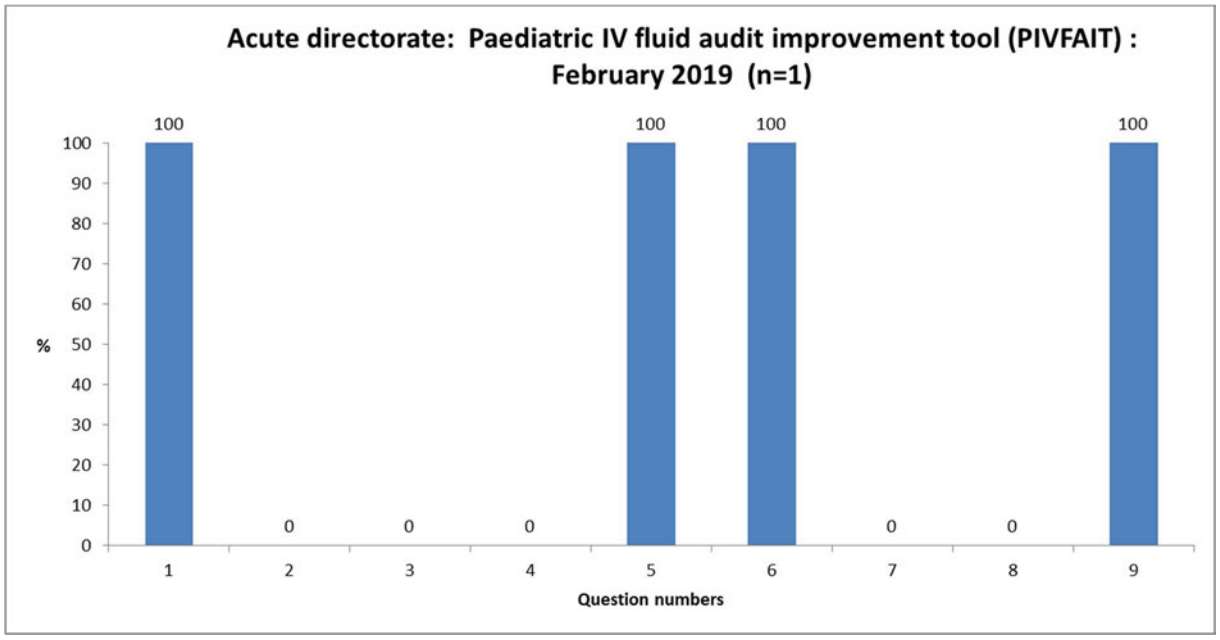
All 9 questions met: 0/1 cases = 0%.

January 2019 (n=1)



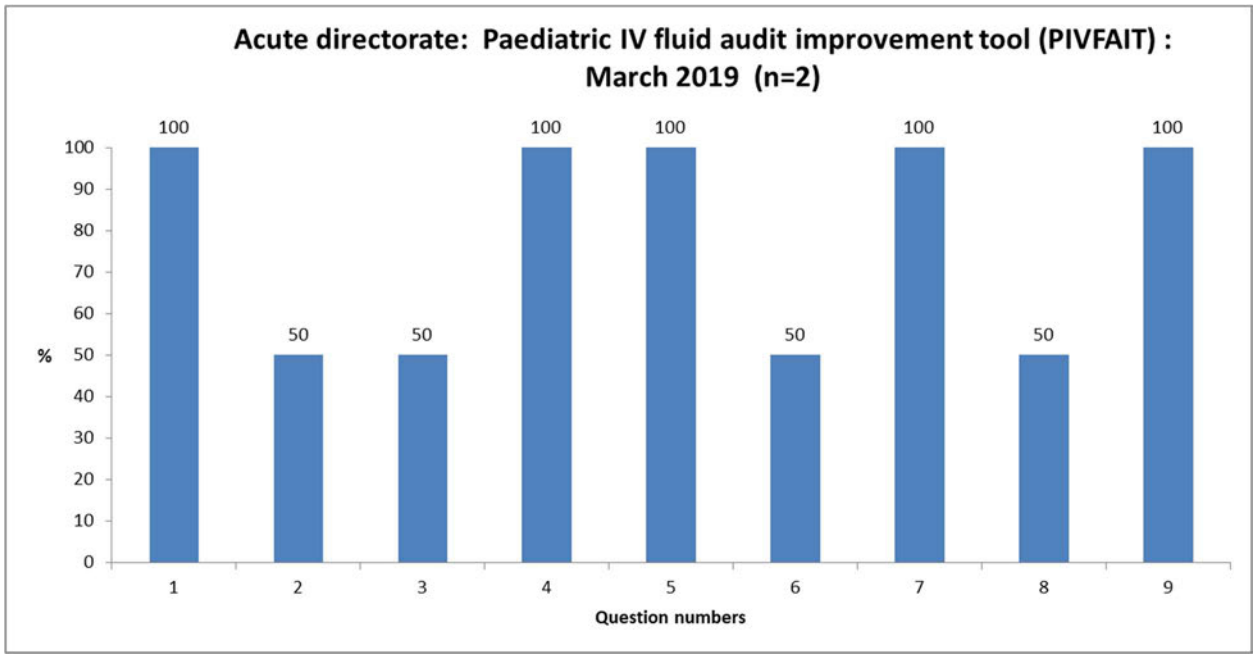
All 9 questions met: 0/1 cases = 0%.

February 2019 (n=1)



All 9 questions met: 0/1 cases = 0%.

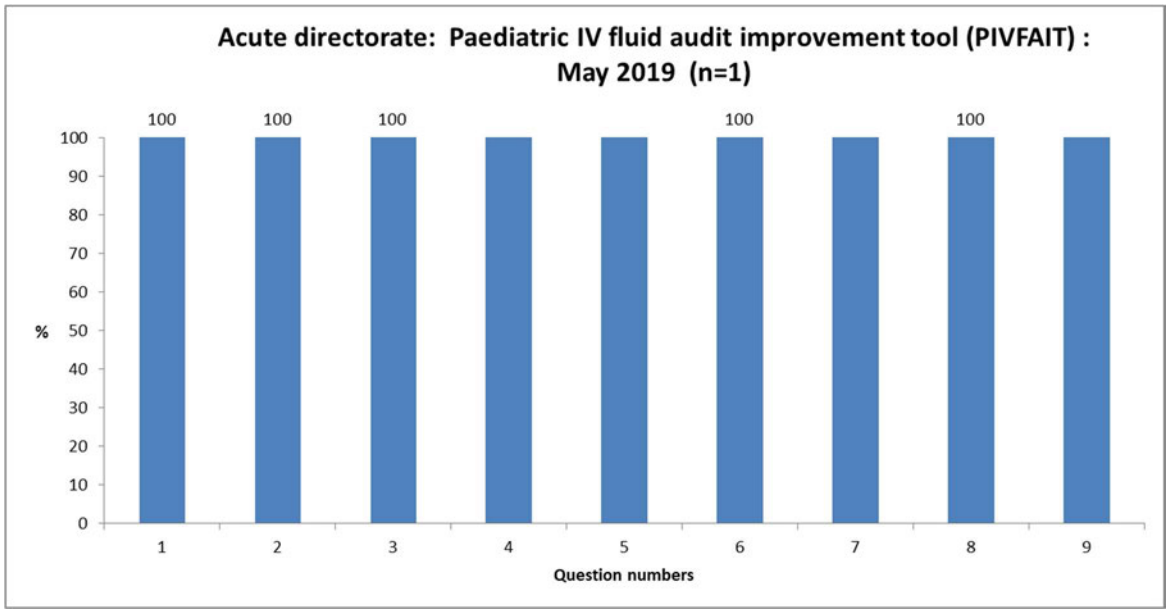
March 2019 (n=1)



All 9 questions met: 1/2 cases = 0%.

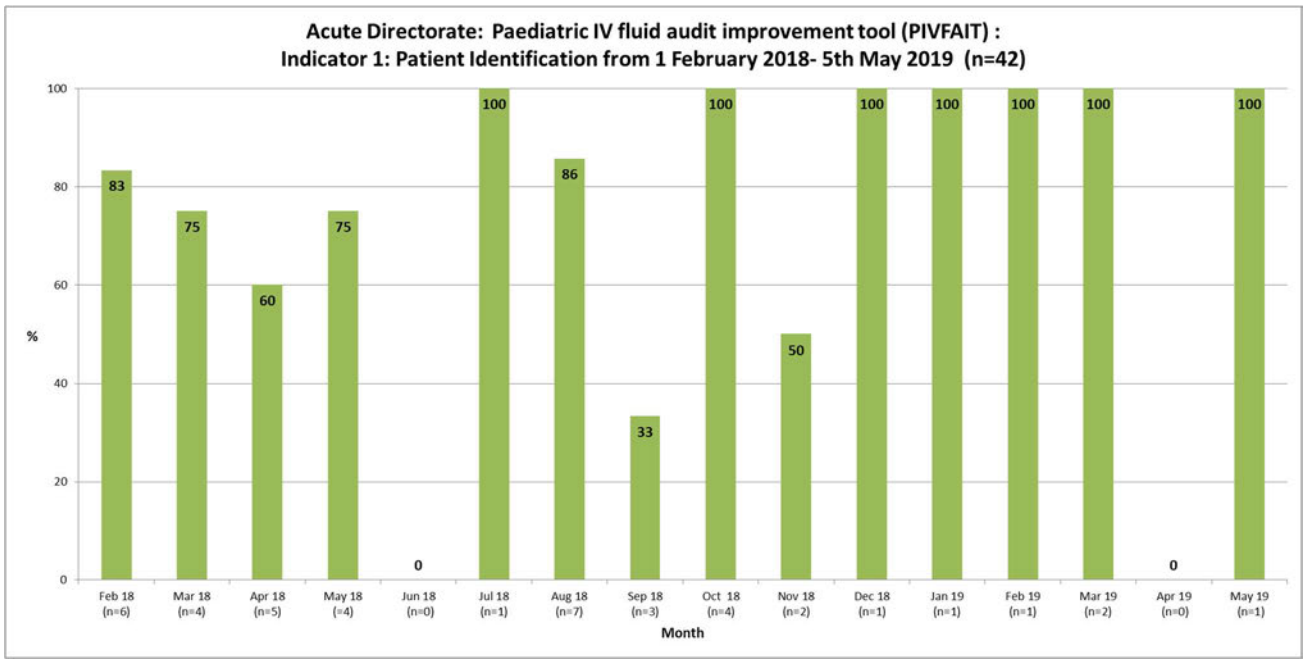
April 2019 – there were no applicable cases for audit.

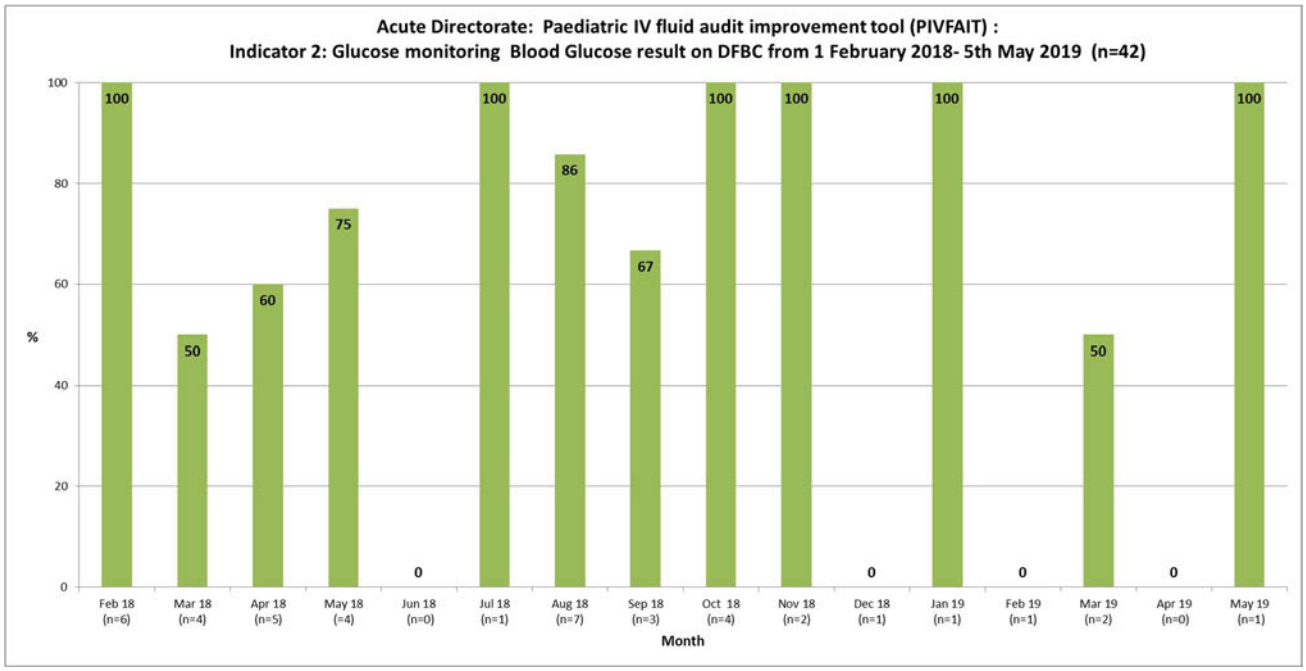
May 2019 (n=1)

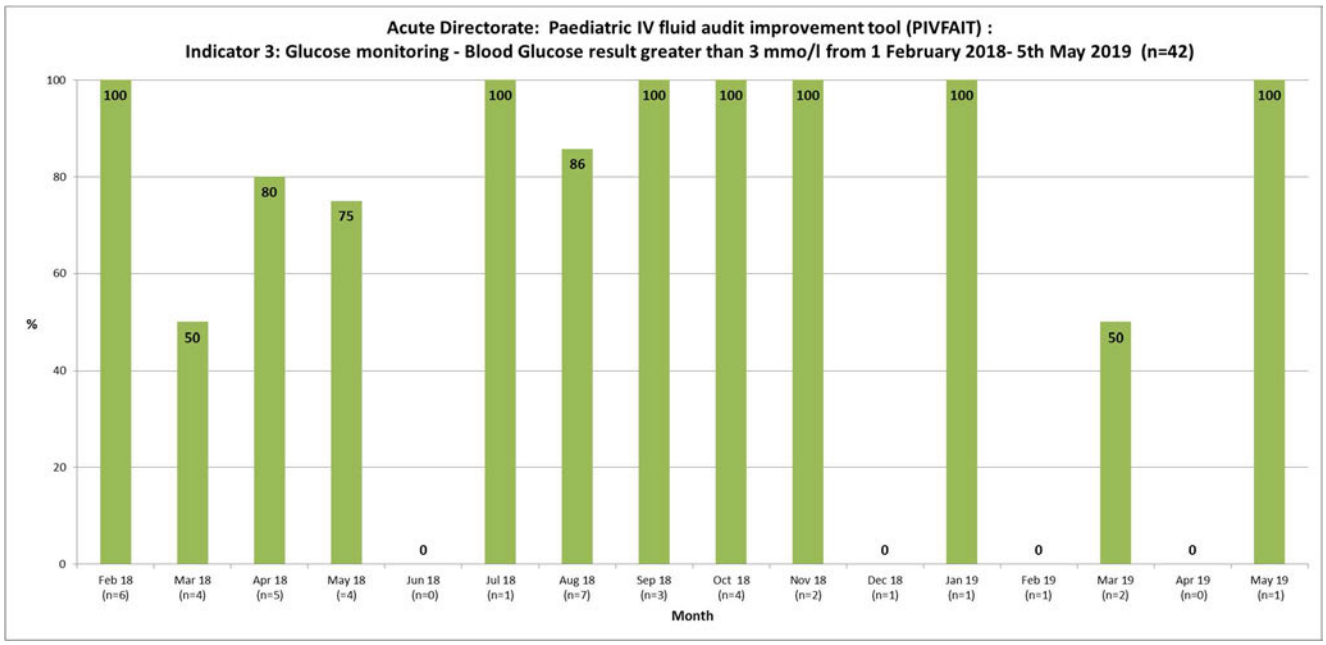


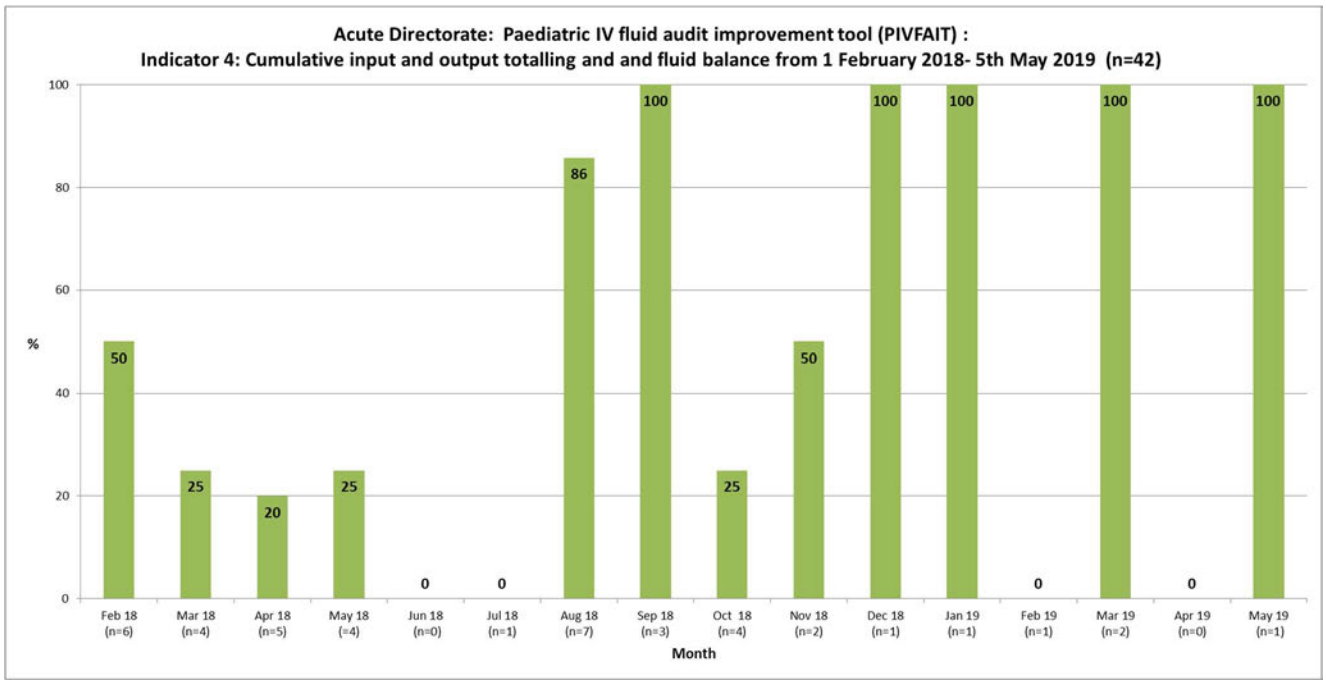
All 9 questions met: 1/1 cases = 100%.

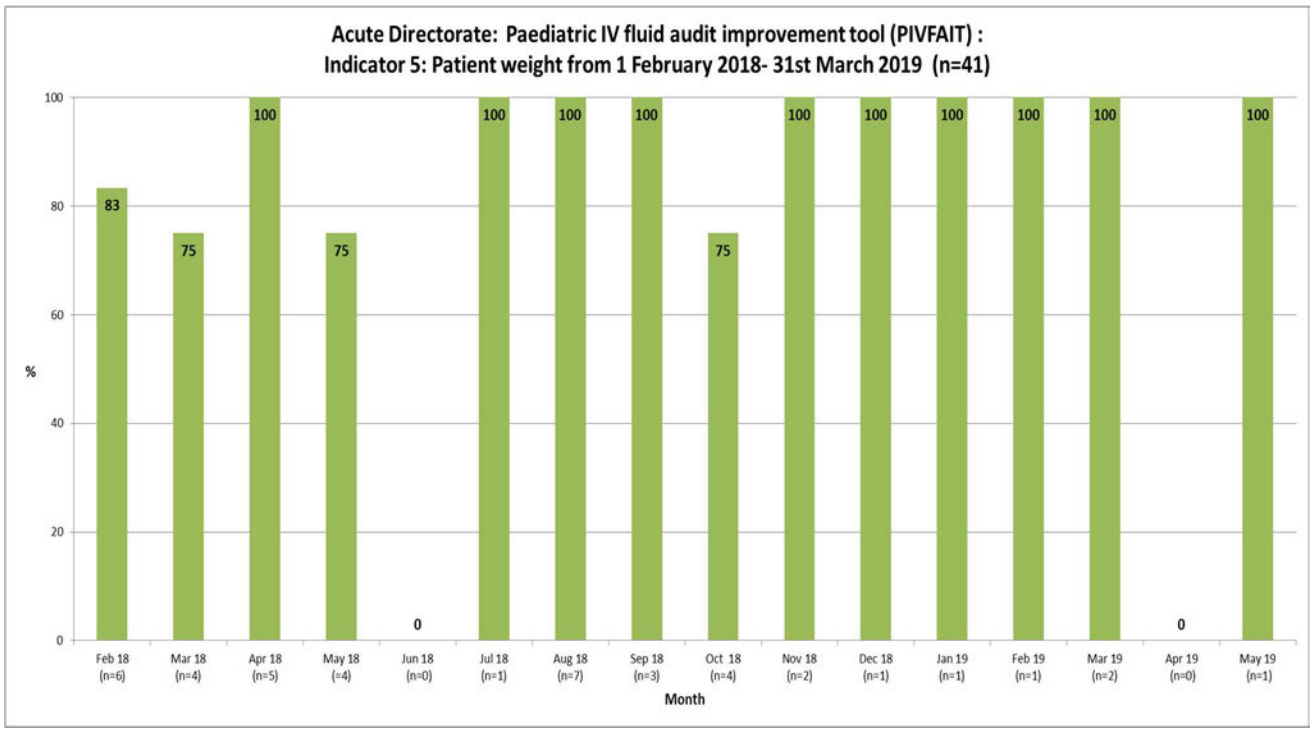
Monthly audit Results: Monthly compliance against each Indicator / Question

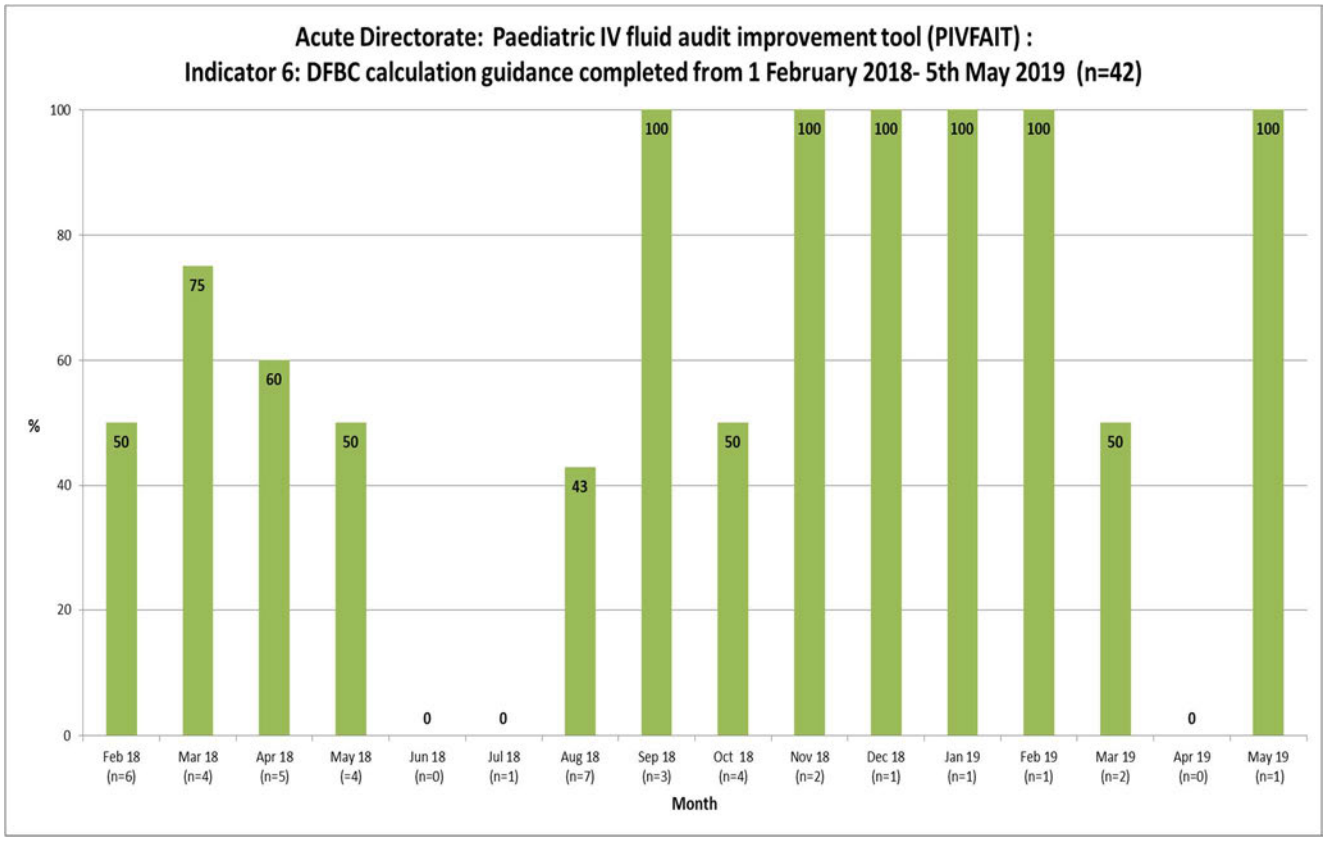


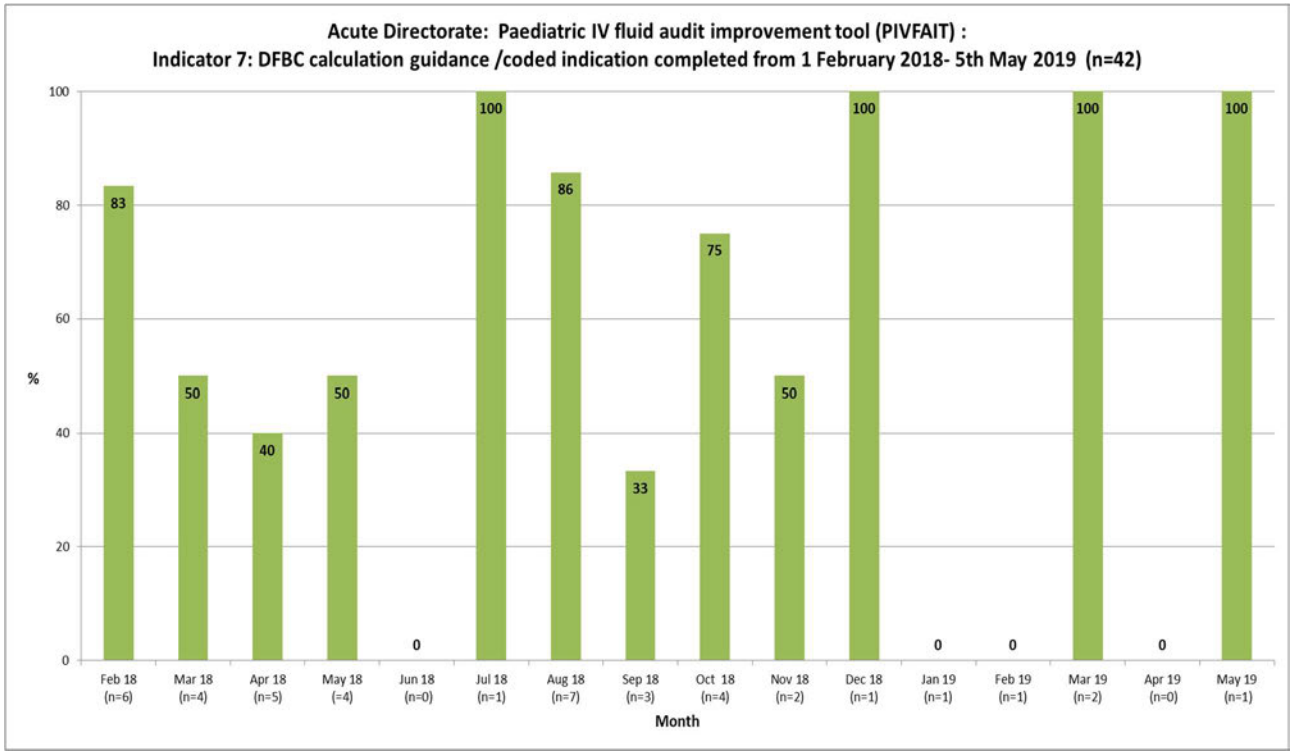


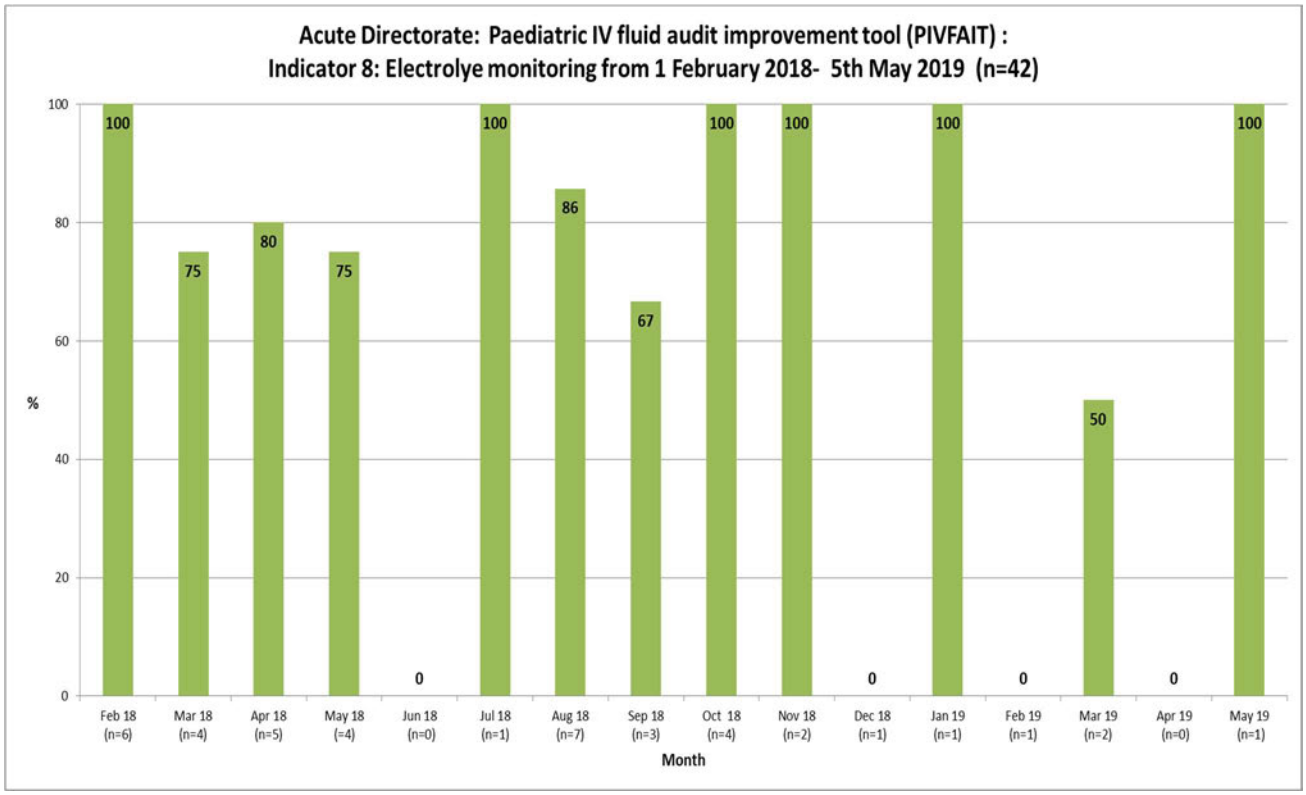

Acute Directorate: Paediatric IV fluid audit improvement tool (PIVFAIT) :
Indicator 3: Glucose monitoring - Blood Glucose result greater than 3 mmo/l from 1 February 2018- 5th May 2019 (n=42)
%
Month
Feb 18 (n=6)
Mar 18 (n=4)
Apr 18 (n=5)
May 18 (=4)
Jun 18 (n=0)
Jul 18 (n=1)
Aug 18 (n=7)
Sep 18 (n=3)
Oct 18 (n=4)
Nov 18 (n=2)
Dec 18 (n=1)
Jan 19 (n=1)
Feb 19 (n=1)
Mar 19 (n=2)
Apr 19 (n=0)
May 19 (n=1)
100
50
80
75
0
100
86
100
100
100
0
100
0
50
0
100

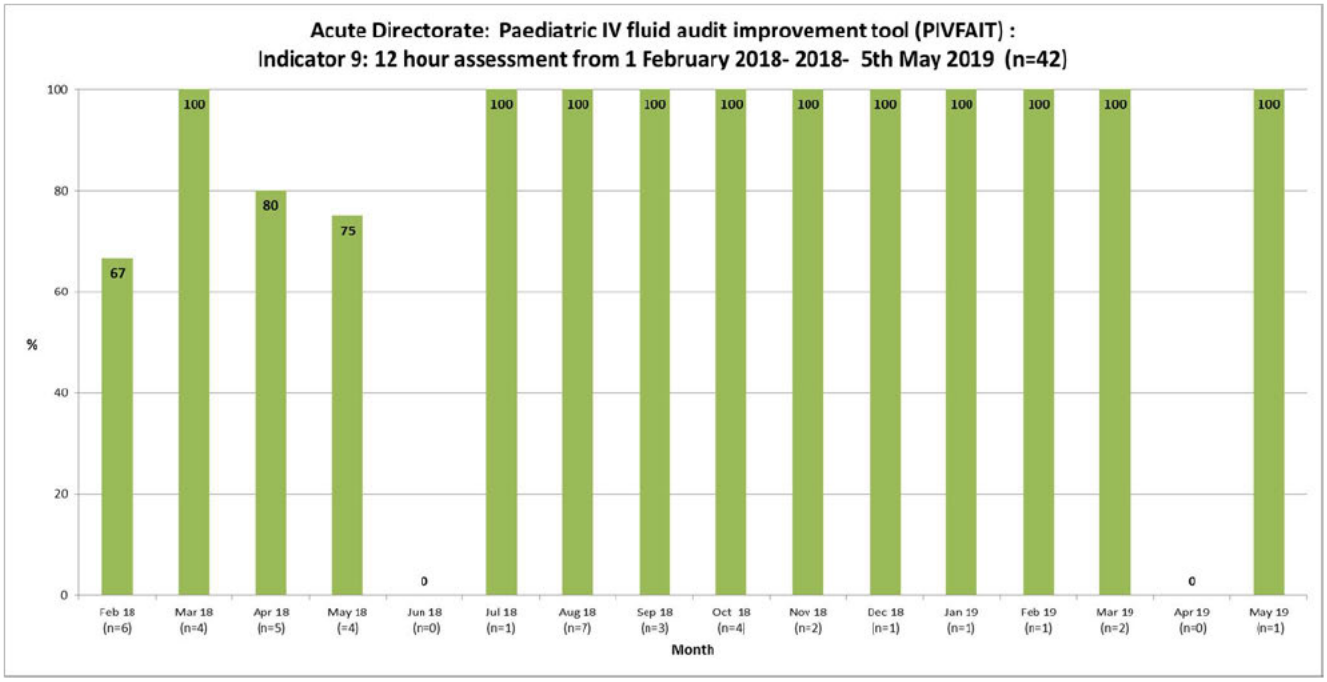

Acute Directorate: Paediatric IV fluid audit improvement tool (PIVFAIT) :
Indicator 4: Cumulative input and output totalling and and fluid balance from 1 February 2018- 5th May 2019 (n=42)
%
Month
Feb 18 (n=6)
Mar 18 (n=4)
Apr 18 (n=5)
May 18 (=4)
Jun 18 (n=0)
Jul 18 (n=1)
Aug 18 (n=7)
Sep 18 (n=3)
Oct 18 (n=4)
Nov 18 (n=2)
Dec 18 (n=1)
Jan 19 (n=1)
Feb 19 (n=1)
Mar 19 (n=2)
Apr 19 (n=0)
May 19 (n=1)
50
25
20
25
0
0
86
100
25
50
100
100
0
100
0
100


Acute Directorate: Paediatric IV fluid audit improvement tool (PIVFAIT) :
Indicator 5: Patient weight from 1 February 2018- 31st March 2019 (n=41)
%
Month
Feb 18 (n=6)
Mar 18 (n=4)
Apr 18 (n=5)
May 18 (=4)
Jun 18 (n=0)
Jul 18 (n=1)
Aug 18 (n=7)
Sep 18 (n=3)
Oct 18 (n=4)
Nov 18 (n=2)
Dec 18 (n=1)
Jan 19 (n=1)
Feb 19 (n=1)
Mar 19 (n=2)
Apr 19 (n=0)
May 19 (n=1)
83
75
100
75
0
100
100
100
75
100
100
100
100
100
0
100


Acute Directorate: Paediatric IV fluid audit improvement tool (PIVFAIT) :
Indicator 6: DFBC calculation guidance completed from 1 February 2018- 5th May 2019 (n=42)
%
Month
Feb 18 (n=6)
Mar 18 (n=4)
Apr 18 (n=5)
May 18 (=4)
Jun 18 (n=0)
Jul 18 (n=1)
Aug 18 (n=7)
Sep 18 (n=3)
Oct 18 (n=4)
Nov 18 (n=2)
Dec 18 (n=1)
Jan 19 (n=1)
Feb 19 (n=1)
Mar 19 (n=2)
Apr 19 (n=0)
May 19 (n=1)
50
75
60
50
0
0
43
100
50
100
100
100
100
50
0
100


Acute Directorate: Paediatric IV fluid audit improvement tool (PIVFAIT) :
Indicator 7: DFBC calculation guidance /coded indication completed from 1 February 2018- 5th May 2019 (n=42)
%
Month
Feb 18 (n=6)
Mar 18 (n=4)
Apr 18 (n=5)
May 18 (=4)
Jun 18 (n=0)
Jul 18 (n=1)
Aug 18 (n=7)
Sep 18 (n=3)
Oct 18 (n=4)
Nov 18 (n=2)
Dec 18 (n=1)
Jan 19 (n=1)
Feb 19 (n=1)
Mar 19 (n=2)
Apr 19 (n=0)
May 19 (n=1)
83
50
40
50
0
100
86
33
75
50
100
0
0
100
0
100


Acute Directorate: Paediatric IV fluid audit improvement tool (PIVFAIT) :
Indicator 8: Electrolye monitoring from 1 February 2018- 5th May 2019 (n=42)
%
Month
Feb 18 (n=6)
Mar 18 (n=4)
Apr 18 (n=5)
May 18 (=4)
Jun 18 (n=0)
Jul 18 (n=1)
Aug 18 (n=7)
Sep 18 (n=3)
Oct 18 (n=4)
Nov 18 (n=2)
Dec 18 (n=1)
Jan 19 (n=1)
Feb 19 (n=1)
Mar 19 (n=2)
Apr 19 (n=0)
May 19 (n=1)
100
75
80
75
0
100
86
67
100
100
0
100
0
50
0
100



Overall compliance

By Month –cases with full compliance per month