Maintaining High Professional Standards in the Modern HPSS

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

Department of Health, Social Services & Public Safety
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MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN HPSS

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CONTENTS *Page*

INTRODUCTION

1. This document introduces the new 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 when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

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

3. Under the Directions on Disciplinary Procedures 2005, HPSS organisations must notify the Department of the action they have taken to comply with the framework by 31 January 2006.

4. The framework is in six sections and covers:

   I. Action when a concern first arises

   II. Restriction of practice and exclusion from work

   III. Conduct hearings and disciplinary procedures

   IV. Procedures for dealing with issues of clinical performance

   V. Handling concerns about a practitioner's health

   VI. Formal procedures – general principles

5. Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist.

Background

6. There has been some concern in the past about the way in which complaints about doctors and dentists have been handled. Developing new arrangements for dealing with medical and dental staff performance has become increasingly important in order to address these concerns and to reflect the new systems for quality assurance, quality improvement and patient safety being introduced in the HPSS.

7. The National Clinical Assessment Authority (NCAA) was established to improve arrangements for dealing with poor clinical performance of doctors. The Department entered into a service level agreement with the NCAA in October 2004 to provide advice and guidance to the HPSS. Since April 2005,

the NCAA has become a division of the National Patient Safety Agency, and is now known as the National Clinical Assessment Service (NCAS).

8. The new approach set out in the framework builds on four key elements:

- appraisal[1] and revalidation – processes which require practitioners to maintain the skills and knowledge needed for their work through Continuing Professional Development (CPD);
- the advisory and assessment services of the NCAS – aimed at enabling HSS Bodies[2] to handle cases quickly and fairly - reducing the need to use disciplinary procedures to resolve problems;
- tackling the blame culture – recognising that most failures in standards of care are caused by systems' weaknesses, not individuals per se;
- new arrangements for handling exclusion from work as set out in Sections I and II of this framework.

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

The new framework

10. At the heart of the new arrangements is a co-ordinated process for handling concerns about the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS. Whatever the source of this information the response must be the same –

- to ascertain quickly what has happened and establish the facts;
- to determine whether there is a continuing risk;
- to decide whether immediate action is needed to manage the risk to ensure the protection of patients;
- to put in place action to address any underlying problem.

[1] Appraisal is a structured process which gives doctors an opportunity to reflect on their practice and discuss, with a suitably trained and qualified appraiser, any issues arising from their work, and their development needs.

[2] In the Direction and Framework "HSS bodies" means: HSS Trusts, HSS Boards and Special Agencies

Under these new mechanisms, exclusion from work must be used only in the most exceptional circumstances.

11. All HSS bodies must have procedures for handling concerns about an individual's performance. These procedures must reflect the framework in this document and allow for informal resolution of problems where deemed appropriate. Concerns about the performance of doctors and dentists in training should 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. The onus still rests with the employer for the conduct of the investigation and any necessary action.

SECTION I. ACTION WHEN A CONCERN FIRST ARISES

INTRODUCTION

1. The management of performance is a continuous process to ensure both quality of service and to protect clinicians. Numerous ways exist in which concerns about a practitioner's performance can be identified, through which remedial and supportive action can be quickly taken before problems become serious or patients harmed, and which need not necessarily require formal investigation or the resort to disciplinary procedures.

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

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

3. All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to establish the facts and the substance of any allegations. Unfounded or malicious allegations can cause lasting damage to a doctor's reputation and career. Where allegations raised by a fellow HPSS employee are shown to be malicious, that employee should be subject to the relevant disciplinary procedures.

SUMMARY OF KEY ACTIONS NEEDED

4. The key actions needed at the outset can be summarised as follows:

   - clarify what has happened and the nature of the problem or concern;
   - consider discussing case with NCAS on the way forward;
   - consider if urgent action needs to be taken to protect the patient/s;
   - consider whether restriction of practice or exclusion is required;

- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

PROTECTING THE PUBLIC

5. From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:
   - arranging supervision of normal contractual clinical duties;
   - restricting the practitioner to certain forms of clinical duties;
   - restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
   - sick leave for the investigation of specific health problems.

6. In the vast majority of cases when action other than immediate exclusion can ensure patient safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

DEFINITION OF ROLES

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

8. The key individuals that may have a role in the process are summarised below:-
   - Chief Executive (CE) – **all** concerns must be registered with the CE who, should a formal investigation be required, must ensure that the following individuals are appointed;
   - the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any

representations from the practitioner about his or her exclusion or any representations about the investigation;

- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CE after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- the Director of HR 's role will be to support the Chief Executive and the Medical Director.

INVOLVEMENT OF NCAS

9. At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides HSS Trusts and practitioners. This includes:
   - immediate telephone advice, available 24 hours;
   - advice, then detailed supported local case management;
   - advice, then detailed NCAS performance assessment;
   - support with implementation of recommendations arising from assessment.

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

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

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

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

13. A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the HPSS or private sector other than their main place of HPSS employment until the NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk. See also circular HSS(TC8) 5/04.

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

INFORMAL APPROACH

15. The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

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

17. In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

IMMEDIATE EXCLUSION

18. When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings eg regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.

19. An immediate time limited exclusion may be necessary

- to protect the interests of patients or other staff;
- where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

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

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

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

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

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

25. The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

26. At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body should be notified. Guidance on the process for issuing alert letters can be found in circular HSS (TC8) (6)/98. This framework also sets out additional circumstances when the issue of an alert letter may be considered.

27. Section II of this framework sets out the procedures to be followed should a formal investigation indicate that a longer period of formal exclusion is required.

FORMAL APPROACH

28. Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CE must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. Several Case Investigators should be appropriately trained, to enable them to carry out this role.

29. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its' costs and resulting action.

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

The Case Investigator's role

31. The Case Investigator:

- must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff[3] with relevant clinical experience in cases where a question of clinical judgment is raised during the investigation process;
- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained. It is the responsibility of the Case Investigator

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

to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered;

- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
- must assist the designated Board member in reviewing the progress of the case.

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

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

The Case Manager's role

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

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

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

Timescale and decision

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

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

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

CONFIDENTIALITY

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

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

TRANSITIONAL ARRANGEMENTS

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

SECTION II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

INTRODUCTION

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

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

3. The Directions require that HSS bodies must ensure that:

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

MANAGING THE RISK TO PATIENTS

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

5. The purpose of exclusion is:

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

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

THE EXCLUSION PROCESS

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

Key aspects of exclusion from work

8. Key aspects include:

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

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

Exclusion other than immediate exclusion

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

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

    (i) the allegation appears unfounded; or

    (ii) there is a misconduct issue; or

    (iii) there is a concern about the practitioner's clinical performance; or

    (iv) the complexity of the case warrants further detailed investigation before advice can be given.

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

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

    - allegations of misconduct;
    - concerns around the functioning of a clinical team which are likely to adversely affect patients;
    - concerns about poor clinical performance; or

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

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

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

(paragraph 30 of Section I defines companion). All discussions should be minuted, recorded and documented and a copy given to the practitioner.

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

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

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

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

Exclusion from premises

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

Keeping in contact and availability for work

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

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

Informing other organisations

22. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers (HPSS and non-HPSS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a HPSS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer[4].

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

24. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called ‘gardening leave’ have been

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

commonly used in the recent past. **No HSS body may use "gardening leave" as a means of resolving a problem covered by this framework.**

Existing suspensions & transitional arrangements

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

KEEPING EXCLUSIONS UNDER REVIEW

Informing the board of the employer

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

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

Regular review

27. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive[5]. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, at any time providing the original reasons for exclusion no longer apply. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

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

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

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to CE and Medical Director. • Each review is a formal matter and must be documented as such. • The practitioner must be sent written notification of the outcome of the review on each occasion.
Third review	If the practitioner has been excluded for three periods: • A report must be made by the Medical Director to the CE: - outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed - a timetable for completion of the investigation. • The CE must report to the Director of Human Resources at the Department, who will involve the CMO if appropriate. • The case must be formally referred back to the NCAS explaining: - why continued exclusion is thought to be appropriate; - what steps are being taken to complete the investigation at the earliest opportunity. • The NCAS will review the case and advise the HSS body on the handling of the case until it is concluded.
6 month review	If the exclusion has been extended over 6 months, • A further position report must be made by the CE to

	the Department indicating: - the reason for continuing the exclusion; - anticipated time scale for completing the process; - actual and anticipated costs of the exclusion. The Department will consider the report and provide advice to the CE if appropriate.

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

The role of the Department in monitoring exclusions

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

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

RETURN TO WORK

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

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

INTRODUCTION

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

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

3. Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation. [6]

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

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

CODES OF CONDUCT

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

   - a refusal to comply with the requirements of the employer where these are shown to be reasonable;
   - an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of

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

doctors and dentists by their regulatory body[7];

- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

EXAMPLES OF MISCONDUCT

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

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

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

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

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

11. Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters

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

would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

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

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

Dropping of charges or no court conviction

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

SECTION IV. PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

INTRODUCTION & GENERAL PRINCIPLES

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

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

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

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

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

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

How to proceed where conduct and clinical performance issues are involved

5. It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If

a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAS adviser and their own source of expertise on employment law.

Duties of employers

6. The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question[8].

7. As set out in Section I (paras 9 - 14), the NCAS can assist the employer to draw up an action plan designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The employing body must facilitate the agreed action plan (agreed by the employer and the practitioner). There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the clinical performance procedure. If so, a panel hearing will be necessary.

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

HEARING PROCEDURE

The pre-hearing process

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

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance hearing. This notification should be made at least 20 working days before the hearing, and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied, and copies of any documentation and/or evidence that will be made available to the panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so wish;
- all parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date

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

should be set for the hearing;

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days notice, to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so;
- Should the practitioner's ill health prevent the hearing taking place, the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary;
- witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.
- If witnesses who are required to attend the hearing, choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

The hearing framework

10. The hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be an appropriately experienced medical or dental practitioner who is not employed by the Trust.[9] No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

11. Arrangements must be made for the panel to be advised by:
    - a senior member of staff from Human Resources;
    - an appropriately experienced clinician from the same or similar clinical specialty as the practitioner concerned, but from another HPSS employer;

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

- a representative of a university if provided for in any protocol agreed between the employer and the university.

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

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

Representation at clinical performance hearings

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

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

Conduct of the clinical performance hearing

15. The hearing should be conducted as follows:

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

- the witness to confirm any written statement and give any supplementary evidence;
- the side calling the witness can question the witness;
- the other side can then question the witness;
- the panel may question the witness;
- the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

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

Decisions

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

<u>Possible decisions made by the clinical performance panel</u>

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;
- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:

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

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

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

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

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

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

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

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

APPEALS PROCEDURES IN CLINICAL PERFORMANCE CASES

Introduction

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

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

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

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

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

The appeal process

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

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

The appeal panel

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

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool.[10] This person is designated Chairman;
- the Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust[11] who must also have the appropriate training for hearing an appeal.

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

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

- a consultant from the same specialty or subspecialty as the appellant, but from another HPSS/NHS employer [12];
- a senior Human Resources specialist.

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

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

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[10] See Annex A.

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

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

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

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

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

Powers of the appeal panel

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

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

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

Conduct of appeal hearing

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

34. The practitioner may be represented in the process by a companion who may be another employee of the HSS body; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative

will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

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

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

Decision

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

Action following hearing

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

Annex A

APPEAL PANELS IN CLINICAL PERFORMANCE CASES

Introduction

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

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

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

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

Creating and administering the list

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

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

6. The Department of Health Social Services and Public Safety, in consultation with employers, the BDA and the BMA will provide a job description, based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competencies featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competencies.

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

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

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

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

INTRODUCTION

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

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

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

HANDLING HEALTH ISSUES

4. On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)[13]. The practitioner may be accompanied to these meetings (as defined in Section I, para 30). Confidentiality must be maintained by all parties at all times.

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

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

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

to resolve the underlying situation e.g. by refusing a referral to the OHS or NCAS.

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

RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

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

Examples of action to take

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

DISABILITY DISCRIMINATION ACT (DDA)

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

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

Examples of reasonable adjustment

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

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

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

SECTION VI. FORMAL PROCEDURES – GENERAL PRINCIPLES

TRAINING

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

HANDLING OF ILLNESS ARISING DURING FORMAL PROCEEDINGS

2. If an excluded employee or an employee facing formal proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures can take place alongside formal procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

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

4. Where a case involves allegations of abuse against a child or a vulnerable adult, the guidance issued to the HPSS in 2005, "Choosing to Protect – A Guide to Using the Protection of Children Northern Ireland (POCNI) Service", gives more detailed information.

PROCESS FOR SMALLER ORGANISATIONS

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

6. Such organisations should consider working in collaboration with other local HPSS organisations (eg other Trusts) in order to provide sufficient personnel

to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the HPSS organisation should contact the Department to take its advice on the process followed and ensure that it is in accordance with the policy and procedures set out in this document.

TERMINATION OF EMPLOYMENT WITH PROCEDURES UNFINISHED

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

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

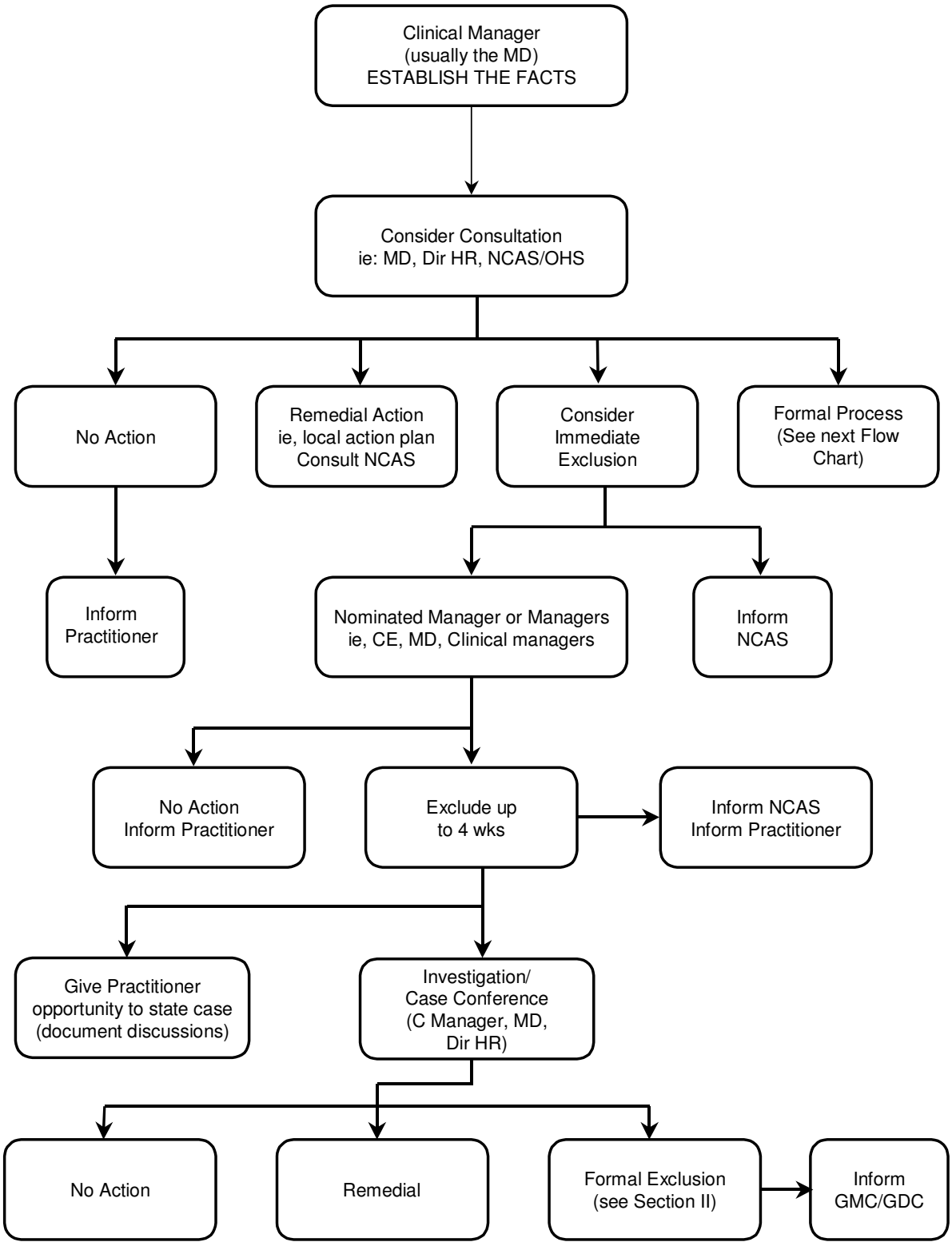
9. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the employer should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same).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

GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT

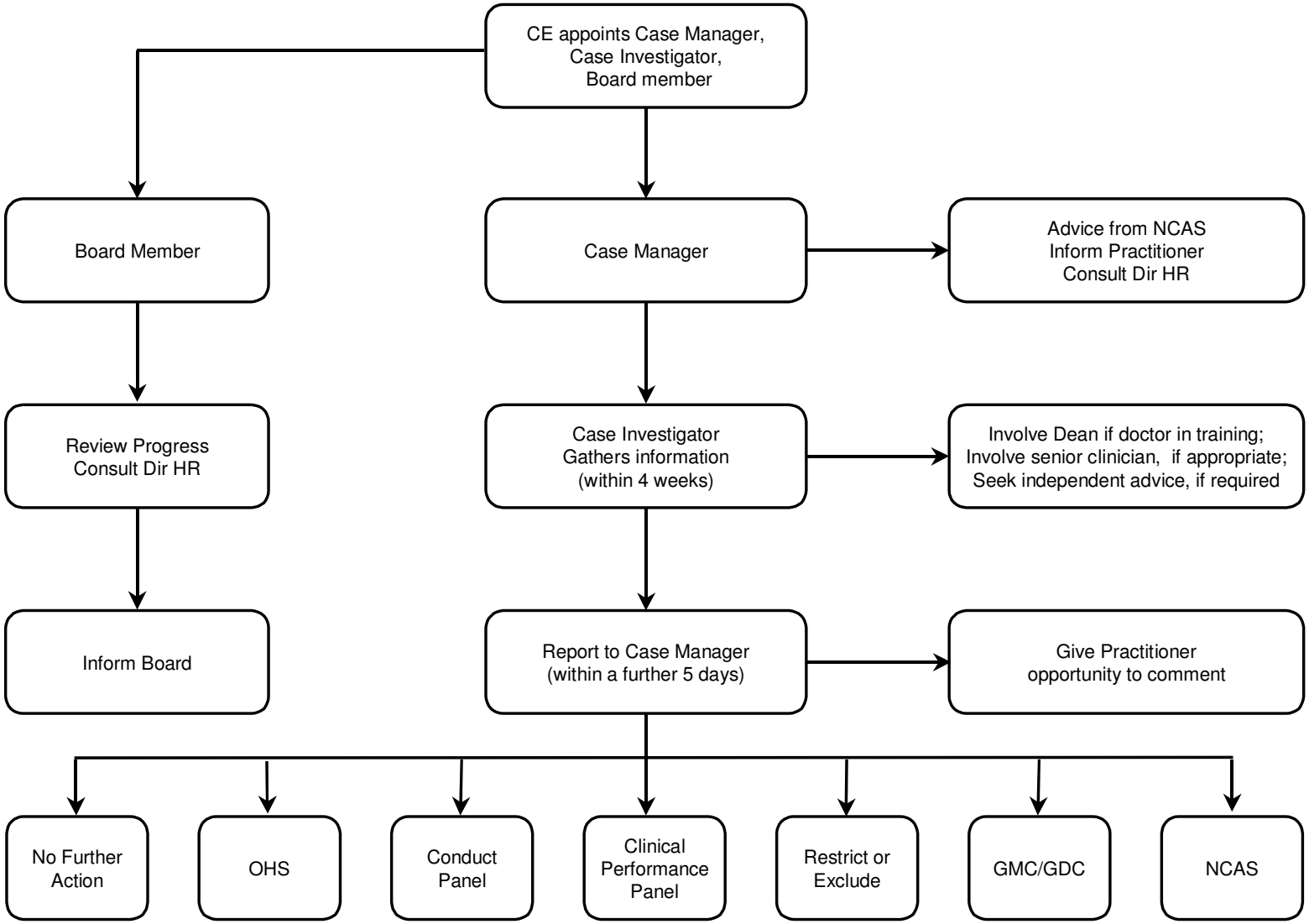
10. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

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

INFORMAL PROCESS



FORMAL PROCESS



24. There were two consultants in the Urology unit in CAH, Mr. Aidan O'Brien and Mr. Michael Young. Whilst I had met both of them before at educational events, I had not worked with either of them previously.

25. The Urology department in CAH at that time had its own inpatient ward. I cannot remember precisely, but there were probably around 20 beds on the CAH Urology ward. The ward would have been fully staffed by nurses on a 24/7 rotation. At the time there would have been a ward sister and deputy ward sister for the Urology ward. The consultants were supported by a number of nurse specialists; nurses who specialised in Urology, having had additional urology training.

26. I was the only Urology Specialist Register in CAH during my rotation, but there were a number of other junior grade medical staff (Senior House Officers and Junior House Officers) also there at the time. Like specialist registrars, they will also have changed over time on rotation. My recollection is that the CAH Urology unit was busy with good training opportunities.

27. Whilst Mr. O'Brien and Mr. Young had their own sets of urology patients, they did do a joint Thursday morning ward round together. I attended this. It meant they were involved with each other's patients. They would also have covered for each other, seeing each other's ward patients, on the weekend rotations and for holidays.

28. I have reflected over time, arising from the questions posed by the USI in the section 21 notice, about the 6 months I spent in CAH. As I have done so, I have recalled that there were a number of situations that arose that caused me to feel concerned about some of the practices of Mr. O'Brien. With the passage of time it is not now possible for me to recall all the details. I did not keep a formal record at the time. I am afraid it would not have occurred to me to do so. I did raise issues that concerned me with Mr. O'Brien himself, and also with Mr. Young about Mr. O'Brien, during my 6 months rotation. In 2000 that would have seemed like a brave or courageous step from a higher surgical trainee. I am sure I probably saw it that way at the time. Whereas, with all the more recent and ongoing changes in medical culture (transparency, openness, and the many mechanisms for raising concerns) and the development of clinical governance (introduced into health and social care around 2003), it hardly seems

sufficient by today's standards when the opportunity for trainees to raise concerns are much more organised and available, and their use encouraged. Trainees are now heard and listened to in a way they would not have been in 2000.

29. As I have reflected on my time in CAH for the purposes of providing this statement it is possible to broadly identify 9 areas of concern that I address below. I would not have counted them up at the time in order to regrade them as some form of accumulation, and would not have had the "slow time" thinking about them facilitated by the questions posed by the USI. It is difficult for me to say whether the concerns I now identify, as I reflect back with hindsight, and with awareness of investigations into Mr. O'Brien, were concerns considered by me to be of the extent and nature that I now see them, and I would ask the USI to bear that in mind. It is also the case that how I responded to the matters that concerned me in 2000 would be different from how I would respond to them today, if I were still a trainee, including because the available mechanisms for responding are significantly different.

30. I should also say at the outset that I recognise and acknowledge that Mr. O'Brien was someone, in 2000, who was a senior consultant. He appeared popular with patients, pleasant to staff, and someone who worked hard (including into the evenings). I also acknowledge him assisting me to secure the opportunity to focus on a particular specialism I was interested in when training in Dublin in 2021.

31. The concerns were as follows:

I. **Patients being admitted to the ward for prolonged intravenous fluids and antibiotic therapy.** There was a group of patients that seemed to me to be being regularly admitted to the ward for antibiotics and IV fluids by Mr. O'Brien. My recollection is that these patients would make contact with Mr. O'Brien in some way and be admitted directly to the ward as an inpatient for treatment. When I asked about this practice the ward nurses referred to this treatment as "*Mr. O'Brien's regime*". I would do an unaccompanied ward round every morning during my 6 months rotation when I would come across these patients. It was often not clear to me the reason for this approach, or the evidence base for the treatment. I considered patients who fell into this category could have been managed as

outpatients, as they could eat and drink. I did not encounter this approach in any other urological unit I worked in before or since.

II. **Cystectomy and Orthotopic neobladder formation.** Amongst the patients coming in for antibiotic therapy and IV fluids was a patient who had had a cystectomy (a major operation to remove the bladder that would generally take between 4 and 5 hours) and neobladder (creation of a new bladder) to treat recurrent urinary tract infections (UTIs). There was a young woman, in her early 20s, who had this procedure before I arrived to do my rotation at CAH, but who then had subsequent admissions for fluids and antibiotics during the time I was in CAH. I am not absolutely certain of the correct name of the patient at this remove, but my legal representative will provide the USI with the name that is in in my memory. The USI may wish to look at the particular case. The young woman made a lasting impression on me as she was really miserable, especially as she was continuing to have UTIs notwithstanding the major operation she had been put through. The predominant indication for cystectomy and neobladder is for treatment of bladder cancer and I was disturbed that this major procedure had been undertaken for recurrent UTIs in a young woman. I could find no evidence base in the literature for this. At the end of a ward round, where I had accompanied Mr. O'Brien, I challenged him as to why he had carried out such a radical and life changing operation on this young woman in the context of recurrent UTIs. He remarked that someone else had said that to him, and he justified it to me by telling me he had specifically discussed this case with a Urologist in the United States of America (USA) who agreed it had been a reasonable course of action. I felt, as a second-year surgical trainee, inevitably anxious about challenging an experienced consultant, that I had expressed my view and Mr. O'Brien had provided an explanation that was hard to dispute at the time. I think this was the only case of this type that I myself saw during my rotation, but I cannot say if there were others with whom this approach was taken. I did speak to Mr. Young during my rotation about various concerns I had about Mr. O'Brien, but I cannot now say whether this was one of the matters that I spoke to Mr. Young about. I may have, but I cannot say that I did. Looking back on this now, with 17 years' experience as a Consultant Urological Cancer Surgeon, I can see no justification for the operation.

So, in relation to this, in summary form, I think the key points is this was a cystectomy and neobladder carried out for benign disease, presumably?

A. (Witness Nods).

366 Q. No suggestion of cancer that might have necessitated the operation. You don't seem to have, and we don't have details of the underlying clinical presentation that might have suggested that it was the right decision and it was the right thing to do. And just given that context, what was it about this lady, I think it mentioned that it stayed with you, I can't remember the sentence, but you recall it quite clearly, it seems?

A. Mm-hmm.

367 Q. What was it about this that raised concerns with you?

A. So, it's highly unusual to remove the bladder in young people unless there's some very unusual congenital abnormality. The main indication for bladder removal is bladder cancer, and my understanding at the time was that she'd had this performed for recurrent urinary tract infections, and I couldn't -- I remember searching the literature at the time and when I prepared the statement looked at the literature and couldn't find any series of patients who had had cystectomy, neobladder formation for a recurrent urinary tract infection.

So I felt, and I still feel, that to put somebody

53. If it was indeed the case that this operation, namely a cystectomy and orthotopic neobladder formation, was performed on any patient for recurrent urinary tract infections alone, without any lower urinary tract dysfunction or other pathology, I would entirely agree with Mr Hagan that that would not be a justification for such surgery. However, I have no recollection of ever performing such surgery for recurrent urinary tract infection alone or having seen such surgery performed for that reason by any other surgeon.

54. It is therefore difficult to comment in any more detail without access to the relevant clinical records and information in respect of this patient.

Trans Urethral Resection of the Prostate (TURP)

55. Mr Hagan provides comments under the above heading at WIT-98847. In particular, Mr Hagan said as follows:

"I was therefore disturbed as a trainee in CAH when a TURP that Mr. O'Brien was carrying out involved a resection that lasted significantly greater than 1 hour. The case I recall involved resection time approaching 2 hours, and the anaesthetist and nursing staff expressing concerns to Mr. O'Brien about the length of operating time, but Mr. O'Brien continued. I thought this was a patient safety issue because it was putting the patient at what I considered to be unnecessary risk. I expressed that view to Mr. O'Brien. Mr. O'Brien's view, as far as I recall it, was that resection time was not the significant issue I considered it to be. I believe I did speak to Mr. Young about this issue (I did speak to him a number of times during my rotation about different issues) and my recollection is of him saying "that's just Aidan".

56. Again, I have not been provided with any evidence of this particular event, or any medical records regarding the patient. It is therefore impossible to comment on this in terms of the specific procedure that took place. However, I would be surprised if Mr Hagan is correct that the resection time was approaching two hours. Such a prolonged resection time implies that the prostate gland was particularly large or that there was difficulty in achieving satisfactory

through. The predominant indication for cystectomy and neobladder is for treatment of bladder cancer and I was disturbed that this major procedure had been undertaken for recurrent UTIs in a young woman. I could find no evidence base in the literature for this… I did speak to Mr. Young during my rotation about various concerns I had about Mr. O'Brien, but I cannot say whether this was one of the matters that I spoke to Mr. Young about. I may have, but I cannot say that I did. Looking back now, with 17 years' experience as a Consultant Urological Cancer Surgeon, I can see no justification for the operation.'

(a) Do the circumstances described by Mr Hagan give rise to any concern from your perspective? Please explain your answer.

(b) Do you recall this issue being raised with you by Mr Hagan? If so, please provide full details of all discussions with Mr Hagan.

(c) To the extent that it is your evidence that you do not recall such interaction with Mr Hagan, please clarify whether it is your evidence that: (i) you do not recall any such interaction or (ii) that no such interaction occurred.

(d) Do you recall any discussions around this issue with anyone else? If so, please provide full details.

2.01 a) I agree with Mr Hagan that the predominant indication for cystectomy and neobladder is in the treatment for bladder cancer. However, in the benign arena, cystectomy is still part of the treatment pathway for such conditions as interstitial cystitis (an inflammatory condition of the bladder), or as part of bladder augmentation in patients with, for instance, spinal injury. Cystectomy and neobladder reconstruction in the younger person is indeed part of the therapy where bodily image may be important for the patient. Cystectomy purely for recurrent urinary tract infections is not standard practice. However, I personally have had only one patient in 30 years of practice who has had a cystectomy for recurrent UTI and this was because of recurrent sepsis and Intensive Care Unit admissions.

2.02 (b and c) I do not recall Mr Hagan raising this issue with me.

III. **Trans Urethral Resection of the Prostate procedures (TURP).** TURP is a core urological procedure for the treatment of benign prostatic hypertrophy, to remove symptoms of bladder outlet obstruction. In 2000, it was performed using monopolar diathermy (a form of electric current) to resect (cut and remove) tissue from the prostate via an endoscopic sheath. Glycine (a potent neurotoxin) 1.5% fluid was used as a non-ionic irrigation fluid in order to maintain vision during the procedure. TURP is generally a safe procedure but carries risks including bleeding requiring transfusion, incontinence, impotence, sepsis and a rare but life threating condition called TUR syndrome. TUR syndrome is caused by absorption of Glycine fluid, leading to Glycine related side effects in the Central Nervous System (CNS), increased plasma ammonia levels and dilatational hyponatraemia. This can lead to serious cardiac, neurological and respiratory side effects and even occasionally death. The key risk factors for TUR syndrome include resection time (greater than 1 hour), height of the fluid bag (greater than 70cm) and large blood loss. TURP is a key surgical procedure for trainees to gain competency. At the time of completing my training in urology, trainees were expected to have completed at least 100 TURPs. Consequently, I would have undertaken most of the TURPs at CAH during my 6 months rotation, which was generally one or two a week. One of the key mantras of the training which I experienced in Glasgow, Belfast, and later Dublin (where I also worked during my 5 years as a surgical trainee) was that resection must stop no later than an hour, and ideally cease by around 50 minutes (to allow for another 10 minutes to control any bleeding). I was therefore disturbed as a trainee in CAH when a TURP that Mr. O'Brien was carrying out involved a resection that lasted significantly greater than 1 hour. The case I recall involved resection time approaching 2 hours, and the anaesthetist and nursing staff expressing concerns to Mr. O'Brien about the length of operating time, but Mr. O'Brien continued. I thought this was a patient safety issue because it was putting the patient at what I considered to be unnecessary risk. I expressed that view to Mr. O'Brien. Mr. O'Brien's view, as far as I recall it, was that resection time was not the significant issue I considered it to be. I believe I did speak to Mr. Young about this issue (I did speak to him a number of times during my rotation about different issues) and my recollection is of him saying "that's just Aidan". I cannot

say for certain that the remark from Mr. Young that I recall was definitely in connection with this issue, but it is definitely a phrase that Mr. Young used to me when I raised an issue about Mr. O'Brien during my time in CAH.

IV. **Ureteric Stone treatment.** There were two different issues in this area. (1) First, emergency admission to urology units for stones in the ureter (the tube connecting the kidney to the bladder) is common. Most stones are less than 1cm in size and around 90% should pass spontaneously without surgical intervention. There was emerging evidence in and around 2000 that prescribing Alpha-blocking medication, such as tamsulosin, could assist stone passage. This conservative management of stones was my experience from working in Glasgow and Belfast. Mr. O'Brien's approach to ureteric stone management was very different and his preference was to intervene surgically at a very early stage. When discussing patient management with Mr. O'Brien, I challenged him in relation to this approach, as I felt that suitable stones should be allowed to pass naturally. This is because intervention carries risks, including sepsis and ureteric perforation. Mr. O'Brien however referred to his training in Tallaght Hospital in Dublin, and that this was how he managed stones. Generally, I found Mr. O'Brien to be dismissive of me when I raised concerns. He was clear that it was an appropriate course of treatment. (2) The second issue related to the energy source used in the destruction of stones. Destruction of ureteric stones requires an energy source. In 2000, there were a number of sources commonly used when operating on the ureter, such as laser and pneumatic devices (such as the swiss lithoclast). Both these types of energy sources had good safety profiles. Mr. O'Brien's preference however was to use an electrohydraulic (EHL) energy source. It was powerful and unpredictable. EHL has uses for large bladder stones and kidney stones, where its use is safe, but, in the ureter, it carries a very high risk of ureteric perforation. I discussed this risk with Mr. O'Brien, as I felt this was a high-risk energy source to use in the ureter, with real safety risks. I described my experience with the lithoclast, which has a zero risk of ureteric perforation, and questioned why he would not use it, as it was very cheap technology. Again, I found Mr. O'Brien to be dismissive of my concerns. Mr. O'Brien did not accept my view. Unfortunately, when carrying out a left ureteric stone case, with Mr. O'Brien directly supervising

time point if there is bleeding or if a little extra time is required to complete the procedure.

3.2 I am aware Mr O'Brien could on occasions perform TURP for more than an hour, however, I was not aware of the duration mentioned by Mr Hagan. It is likely that all Units will have examples of TUR Syndrome but I am not aware of Mr O'Brien having a higher incidence of TUR Syndrome than anyone else.

(b) Do you recall this issue being raised with you by Mr Hagan? If so, please provide full details of all discussions with Mr Hagan.

3.3 I do not recall a precise conversation on this case as it was 23 years ago, however, if Mr Hagan had raised an issue such as this I would have asked him had there been TUR Syndrome with this patient.

(c) Do you recall responding to Mr Hagan in the manner he has suggested?

3.4 With regards to the phrase "that's just Aidan", it is a phrase that I, as well as others, would have used in general terms. However, it certainly would not have been a phrase I would have used when responding to someone commenting upon a TURP of that duration.

(d) To the extent that it is your evidence that you do not recall such interaction with Mr Hagan, please clarify whether it is your evidence that: (i) you do not recall any such interaction or (ii) that no such interaction occurred.

3.5 I do not recall any such interaction regarding the TURP case that Mr Hagan has raised.

(e) Do you recall any discussions around this issue with anyone else? If so, please provide full details.

3.6 I have no recollection of having discussions regarding this issue with others. As indicated at 3.2 above, I recall being generally aware that Mr O'Brien had on occasions taken more than 1 hour for a TURP. I believe I was aware of this informally (e.g., through theatre tea room chat) and, as also mentioned at 3.2 above, not because of any awareness of Mr O'Brien having any higher incidence of TUR Syndrome.

4. In oral evidence on Day 61 (TRA-07937), Mr Hagan stated as follows:

"So, I know I discussed issues with Michael Young, and stone treatment was one of them, and the use of EHL in the ureter, you know, would have been part of that conversation because it wasn't something that I had ever encountered before. And I know that I had discussions about purchasing a lithoclast and safer ureteric surgery."

Having regard to the above, and Mr Hagan's evidence at WIT-98848 in respect of Mr O'Brien's approach to ureteric stone treatment, which he describes as 'very different', please address the following:

(a) Please provide a narrative account of your experience of ureteric stone treatment using electrohydraulic lithotripsy. Please provide any comments you may have in respect of the safety of the use of EHL in the ureter.

4.1 EHL was one of the accepted technologies used to fragment stones in the urinary tract in 2000. There were different electrode probe sizes available to be used depending upon which part of the urinary tract they were to be used in. Most Registrars would have seen it used in bladder stone fragmentation. The probes for ureteric use were very fine so they could be passed up the thin ureteroscope and were flexible. This flexibility aided use in the proximal ureter or within the kidney if used with a flexible uretero-renoscope.