Review of Maintaining High Professional Standards in Northern Ireland

Final Report:

Submission to the Department of Health from the Independent Review Panel

July 2024

The Independent Review Panel

The Independent Review Panel was commissioned by the Department to take forward the review. They each bring differing expertise to the project covering: Operational Experience of the MHPS Framework; Medical Leadership/Governance; Employment Law/Rights Knowledge; and Restorative just & learning practices.

Acknowledgements

The Independent Review Panel wishes to thank all those who facilitated this Review by participating in discussions, meetings, surveys and by providing relevant information.

Membership of the Independent Review Panel

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Executive Summary

Background / Context

Maintaining High Professional Standards in the Modern HPSS – A framework for the handling of concerns about doctors and dentists in the HPSS (MHPS[1]) is a framework for handling performance concerns regarding doctors and dentists employed in the HSC, whether these arise from their conduct, clinical capability, or health. The framework has been in place since 2005 and does not reflect subsequent system and regulatory reform. In recent years, the MHPS process and its application has come under scrutiny and criticism both from those who operate it at a local level and through a number of Inquiries.

In May 2023, the Department of Health (DoH) established the Independent Review Panel to examine the application and effectiveness MHPS. The review team drew on a wide range of evidence to inform its assessment, including analysis of previous reviews and Inquiry outputs, questionnaires on the operation of the process, written submissions, and a wide range of engagement sessions.

Findings

The Review Panel determined that it is difficult to disentangle how much of the issues raised are a product of what is written, or how it is applied within the context of the organisational culture, or how much is a reflection that MHPS no longer fits with the current landscape. Irrespective of reason, the review panel agreed that revised arrangements are necessary.

In considering the current version of MHPS, the Review Panel identified four fundamental areas as part of its review; these were:

- The Purpose of MHPS

  Whilst the overall purpose of the framework is to support the resolution of performance concerns largely through what it terms an “informal approach,” it is questionable whether it achieves this to the fullest extent possible. One element in this failure is its exclusive focus on medical and dental staff. A related

[1] https://www.health-ni.gov.uk/node/69104

issue is the association of an “informal approach” with an absence of rigour and documentation.

- The MHPS Process
  The process was generally considered cumbersome and confused with increased potential towards premature formality. In addition, those charged with conducting the process were possibly least well equipped to progress it effectively, certainly without supporting expertise.

- The Roles, Responsibilities and Rights of those involved in the MHPS Process.
  The framework over- specifies roles whereas these should derive naturally from (and certainly should not be in conflict with) individual’s day to day roles. Clarification of rights at different stages of the process is articulated.

- The Oversight, Governance and Accountability of MHPS
  Proper accountability and reporting arrangements are recommended in keeping with current practice.

Conclusion

The conclusion of the Independent Review Panel is that the current MHPS process for handling concerns about the conduct, clinical performance and health of doctors and dentists employed in the HSC is no longer achieving the intended purpose and puts forward the following recommendations to address the issues found.

Recommendations

We have made a total of **24 recommendations** in this report.

Summary of Recommendations

The following recommendations are made to support the delivery of new procedures across the HSC for the handling of concerns for all HSC employed staff to include doctors and dentists who are currently subject to MHPS. Where concerns are referred to in this report, these are concerns that relate to an individual's performance (whether these arose within the workplace, or occurred outside the workplace that might affect their performance or standing within the workplace) which might arise from their conduct, capability, or health (or a combination of these)

If recommendations one to four below are accepted and implemented these would replace the existing MHPS framework.

The Purpose of MHPS	
Number	**Recommendation**
1	Medical and Dental practitioners should be subject to the same HR policies that address performance concerns applicable to other HSC employees.
2	The Regional Disciplinary Policy and Procedure should be amended to include Medical and Dental staff from the initial raising of a concern. Its universal adoption by all HSC employing organisations should be mandated by the Department.
3	The Regional Disciplinary Policy and Procedure should be used as a template to develop a separate regional document to address capability issues which applies to all HSC staff including medical and dental staff and its universal adoption by all HSC employing organisations should be mandated by the Department.
4	The Regional Disciplinary Policy and Procedure should be used as a template to develop a separate regional document to address health related performance issues which applies to all HSC staff including medical and dental staff and its universal adoption by all HSC employing organisations should be mandated by the Department.

The MHPS Process	
Number	**Recommendation**
5	Current and future replacement processes must include an initial consideration of a concern that affects an individual's performance whether this arises from a potential conduct, capability or health issue and should involve a screening process. This screening should be part of day-to-day management and should help inform what if any action is required, including whether there is a conduct, capability or health issue or a combination of these.
6	If at the conclusion of the screening process, a clear course of action has not been determined from the information gathered, Terms of Reference should be drafted for a subsequent investigation. A case manager and case investigator should be appointed at this stage. The Terms of Reference for an investigation must be shared with the practitioner before the investigation commences. Any information shared with the investigator must also be shared with the practitioner. The investigation report must address and answer the Terms of Reference and be evidence based. The investigation report prepared should set out the context and situation and the findings considered within a band of reasonable responses given these factors. The practitioner must be given a copy of the report to enable them to comment on any matters of factual accuracy before the report is finalised.
7	Current and future replacement processes must be fair, open and transparent with the practitioner and the practitioner should be made aware of the initial concern and information available at the outcome of the initial screening process and be given the opportunity to respond.
8	Employing organisations should identify individuals to contribute to a dedicated pool to support processes (predominately investigations) within individual organisations. Case managers and case investigators must have dedicated time identified and receive on-going training aimed at maintaining a range of up-to-date knowledge, skills and experience.

9	The justification for any referral to another party must be recorded and should only happen when there is clear evidence that it is necessary to do so to protect the safety of patients, staff or public and or the efficiency of HSC services and the practitioner should be informed of this.
10	Information must be shared with the doctor's RO and the RO must be kept informed of investigations and/or questions raised regarding a doctor's fitness to practise. Where there are serious concerns raised about a doctor's practice and it is known that the doctor has additional scopes of work outside of the primary employing authority, there should be a discussion with the other employing/contracting organisation followed by appropriate information sharing.
11	If the assessment of the concern indicates a risk to the practitioner and or service and an exclusion or restriction is put in place these arrangements must be reviewed at least every 28 days and the rationale for either maintaining the exclusion/restriction or revoking/amending must be recorded.
12	Any relevant timescales specified in the relevant policy must be reasonable, promote timeliness and consider foreseeable delays. Any delays should be recorded together with the justification for it. The practitioner must be informed at the earliest opportunity.
13	Confidentiality should not impinge on patient safety aspects or the utilisation of information, but good information governance should be adhered to, and awareness should be raised on ways of achieving this. The personal data guardian should be consulted as appropriate regarding qualified confidentiality.

Roles & Responsibilities and Rights of those involved in the MHPS process	
Number	**Recommendation**
14	The Case Manager should be the most appropriate person to manage the case and the role should not be limited to a clinician. The CM must be responsible for the drafting of Terms of Reference for investigations, receiving and reporting on the management of the case and preparing reports for consideration by the relevant decision-making group. They must also provide the practitioner with an update on their case every 28 days (even when there is no update). They must play no part in decision making on the case.
15	HR should nominate a named point of contact between the practitioner and the employer, and they should signpost the practitioner to health and wellbeing services (internal and external). The HR point of contact must make contact with the practitioner every 28 days for a health and well-being check.
16	HSC Employing organisations should acquaint themselves with where they can seek either advice or services that might help with an assessment of the presenting concern and this should be extended to where the practitioner can be signposted to.
17	The relevant policies on managing the performance concern must provide clarity on the parameters and circumstances that allow an employee to be accompanied and the circumstances as to when they can be represented as making provision for either right in the investigation process has proved counterproductive especially given that the statutory right applies to hearings only. Arrangements should ensure that these rights appropriately support the practitioner at the appropriate juncture in the process and that they are not counterproductive to advancing the case in a fair, timely and open manner.
18	All decision making should be carried out by a panel, this is for both the screening stage and other stages of decision-making. It does not need to be the same panel for each stage. Panels should be drawn from individuals who have had no prior involvement in the matters to be considered. Good practice suggests a panel should consist of no less than three-members.

19	The RO must be kept informed of issues that arise about a doctor's fitness to practise.
Oversight, Governance & Accountability of the MHPS Process	
Number	**Recommendation**
20	HSC employing organisations should be able to demonstrate effective internal governance protocols which are consistent with NI HSC principles with oversight and clear lines of accountability. These should include standardised provisions regarding role clarity and be predicated on contemporary governance protocols in use in other parts of the public sector in Northern Ireland.
21	Regional templates should be developed and uniformly adopted to record a data set of all performance concerns raised and the management and disposal of it.
22	Reports should be provided to the Board of the employing/contracting organisation on a quarterly basis detailing metrics and themes.
23	HSC employing organisations should be required to submit an annual report to the Department, which should include, activity figures, outcomes and lessons learnt.
24	HSC employing organisations should review their record retention policies to ensure that they are retaining information such as complaints and issues relating to a doctors/dentist's practise for the duration of their medical/dental working career and ensure this complies with GDPR provisions.

1.0 Background and Context

1.1 Introduction

Health and Social Care is delivered throughout Northern Ireland daily by staff of all types, working individually or in teams to provide the best possible care they can; and most services are carried out without any concerns about the safety of patients posed by the performance of doctors and dentists. However, it is inevitable that at times concerns will be raised about the conduct, clinical performance and/or health of doctors and dentists. It is a fundamental requirement of good governance that there are organisational systems and processes in place that address such concerns in a prompt, effective and proportionate manner.

Since 2005, the regional framework for handling such concerns arising about doctors and dentists employed in the HSC has been *Maintaining High Professional Standards in the Modern HPSS* (MHPS)[2]. In its introduction, the Framework states *"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."* Over recent years, questions have arisen over whether the Framework and its implementation have met this aim.

1.2 Context

1.2.1 What led to this review.

Over the years of MHPS' operation, there has been disquiet as to whether or not MHPS is fit for purpose for a number of reasons, this includes wider workforce and personnel policies, changing regulatory requirements, high profile cases both locally and further afield which make reference to MHPS. To an extent this disquiet has arisen from case decisions from industrial tribunal through to the court of appeal who have paid close attention to the processes that informed the decision-making surrounding

[2] https://www.health-ni.gov.uk/node/69104

matters of discipline and dismissal. This scrutiny has increased over the years of MHPS' operation and has not been a sector specific process but rather looking at the broad construct in the round such as:

- Procedural clarity – covering - roles, functional responsibility, accountability, constructive knowledge of process.
- The quality of the investigation and the direct correlation to the quality / procedurally correct / substantively fair decision derived from the investigation.
- Adherence to process – covering – clarity of terms of reference, due regard to timeframes, obviation or deviation from process.
- Interaction with other related or overlapping procedures or counter invocation of policies and procedures.
- Foreseeable consequences associated with matters such as – delays due to sickness absence, demands for anonymity, conflicting interpretations of provisions, perceived process weaponisation, whistleblowing incidents.
- Substantive fairness predicated on broad notions of natural justice regarding, for example, the right to a fair hearing, right of reply.
- An increasing tendency towards an adversarial approach rather than inquisitorial or restorative approaches which result in in-house processes bearing all the hallmarks of court-like protocols.

It is with this as a contextual backdrop that MHPS was exposed as effectively having fallen foul of and as such in part informed the need for the review.

It is evident, not least because the framework was first introduced in 2005 together with the two reviews that did not complete, that a substantive review of the MHPS policy is overdue and was thus made a priority for the Department.

1.2.2 Local Cases / Inquiries

The Independent Neurology Inquiry, published in June 2022, highlighted issues with the operation and implementation of the MHPS process and made recommendations for improvement that need to be reflected within any future arrangements. It made three specific recommendations with respect to MHPS as well as recommendations as to how the HSC more widely deals with the raising and investigation of concerns surrounding an individual's clinical practice.

The Urology Services Inquiry commenced in June 2022. A full module was held on MHPS, and observations were made throughout the inquiry. The inquiry has not yet concluded but the observations and witness statements have been taken into consideration by the panel and they have helped to inform the issues that need to be addressed.

1.2.3 Previous Reviews

Two previous reviews (2011 and 2018) were commenced by the Department which highlighted issues with the policy, but for reasons that are not clear, neither completed.

1.2.4 Policy and Legislative Context

At approximately the same time that MHPS was being implemented in 2005 the law on discipline, dismissal and grievances was being amended in Northern Ireland via Statutory Regulations[3] derived from Part IV of the Employment (NI) Order 2003.

The nature of this and other legislation such as the Public Interest Disclosure (NI) Order 1998[4] is relevant to how MHPS has been operated and applied.

With regard to employment investigations many cases have been taken before employment tribunals and the Employment Appeal Tribunal (GB only) which have the employment investigation at the heart of the judicial decision. Such cases only have persuasive value in the Northern Ireland jurisdiction. However, each case will turn on its own facts, merits and context, as will the expectations given the size, nature and resources at the disposal of the employer.

1.2.5 Developments in Professional Regulation

1.2.5.1 *Responsible Officer Regulations*

Whilst MHPS makes reference to medical revalidation, it pre-dates its introduction. The Responsible Officer (RO) Regulations came into effect in December 2012. From that date, organisations who employ or contract with doctors (termed Designated Bodies (DBs) in the regulations), were required to appoint a Responsible Officer who has a range of the duties set out in the regulations.

[3] www.legislation.gov.uk/nisr/2004/521/contents/made
[4] www.legislation.gov.uk/nisi/1998/1763/contents

In summary, relevant duties of the RO include, but are not limited to:

- ensuring that the (employing authority) carries out regular appraisals on all connected doctors.
- establishing and implementing procedures to investigate concerns about any doctor's fitness to practise and referring concerns to the GMC.
- making recommendations to the GMC about doctors' fitness to practise.
- maintaining appropriate records in relation to any of their responsibilities.

The effective fulfilment of these duties is collectively referred to as 'revalidation processes' that enable an RO to make a recommendation to the GMC every five years to enable individual doctors to retain their licence to practice.

In most DBs, the Medical Director is also the RO. The RO regulations prescribe how a doctor connects to a Responsible Officer and prescribes the duties that the DB and the RO must fulfil, The RO being a registered medical practitioner is accountable to the GMC. The regulations are supported by regional guidance[5] and the GMC provide guidance for ROs, in relation to the management of concerns and the expected governance associated with making revalidation recommendations to the GMC. It is expected that the RO should have at their disposal processes to manage concerns such as those set out by the DB in its local policy to assist them in fulfilling their statutory obligations.

Given the overlap between the professional and contractual role of the MD and the statutory role of the RO, the review panel were cognisant that any reform/replacement of MHPS must take this into account.

1.2.6 Independent Contractors

At the outset of its work, the review panel considered whether there was merit in expanding any new revised arrangement and were mindful that doctors and dentists in primary care are independent contractors with the HSC to deliver services, working under the terms of a contract for services to deliver primary medical services or primary dental services. Primary Care doctors are managed in accordance with the Medical Performers List regulations. Notwithstanding this, many are salaried or employed by

[5] https://www.health-ni.gov.uk/publications/medical-profession-responsible-officers-regulations-ni-2010-and-accompanying-guidance

a doctor or dentist who holds the contract for services. These arrangements are not dissimilar from a small business unit.

Previous reviews have mooted that consideration should be given as to whether or not all doctors and dentists should be governed under the same policy for managing performance concerns regardless of the setting in which they work. The review panel recognise that the contractual arrangements within primary care are different to those in the HSC. In the case of medical practitioners, The Performers List regulations provide a prescribed legal framework for addressing concerns regarding doctors providing primary medical services irrespective of employment status.

As these arrangements are well established and largely mirror arrangements across the UK, the review panel agreed that it should focus its attention wholly on arrangements for doctors and dentists employed by HSC organisations.

1.2.7 Dispute Resolution

The years since 2005 have seen developments in internal dispute resolution cultures in the public sector with more contemporaneous approaches looking towards open, just and learning cultures which have a more restorative than retributive approach. Cultural reform is not achieved by policy amendment alone and success will be underpinned by mindset and organisational shifts in approach. Mersey Care (see later in report) has been cited as an exemplar of such cultural reform and the review panel has taken the time to meet with relevant individuals within Mersey Care and examine the impact of their approach.

As a central plank of an aspect of individual dispute process MHPS has developed a culture of its own and this has been highlighted via the responses to engagement the panel has received.

1.3 Establishment of the Review

In November 2022 the Department of Health (DoH) Permanent Secretary, Peter May, committed to a review of MHPS being commissioned by the Department but conducted by experts external to the Department.

2.0 Terms of Reference

The terms of reference for this review, as signed off by the Project Steering Group were as follows:

1) To consider the definition of roles and responsibilities identified within the MHPS Framework.

2) To make recommendations as to the scope of the MHPS Framework – whether a separate process to manage doctors and dentists' performance is required within HSC.

3) If it is recommended that MHPS is required, then to consider if there a case to extend the framework's scope to include other professions.

4) To consider the application of the MHPS Framework and the appropriateness of the content and structure of the MHPS framework including suggested timescales and consideration of the processes associated with its operation.

5) To consider the application and use of the MHPS framework across HSC including learning from relevant legal proceedings, inquiries, case law etc.

6) To consider the interaction between the informal and formal investigation stages of the framework.

7) To consider the changes made to the MHPS and the equivalent Framework(s) operating in other jurisdictions and provide recommendations as to what improvements could be incorporated into a NI Framework.

8) To consult with a range of stakeholders who have been involved in operation of the MHPS Framework locally, including those who have used the processes and guidance within HSC organisations.

9) To consider how national and regional work ongoing in the NHS / HSC relating to restorative just and learning culture impacts on the content of MHPS Framework and how concerns about doctors and dentists are addressed.

10) To determine the skills development or training needed for those operating the MHPS Framework in/across HSC.

11) To consider the interaction(s) between the MHPS framework and other codes of conduct and performance management systems within HSC organisations as well as other Department and regional policies (such as Whistleblowing, Conflict, Bullying & Harassment) and ongoing work in relation to Being Open, HSC Complaints and Serious Adverse Incidents policies, and interface with Early Alert protocol where relevant.

12) To make recommendations with respect to development of a guidance element of the MHPS Framework to ensure it is fit for purpose, clear to follow and compliments existing organisational policies for performance management of all staff.

13) To produce a final report setting out key findings and recommendations.

14) To produce a draft revised version of the MHPS Framework

15) To produce guidance to support operation of the framework across HSC.

3.0 Review Methodology

The review used a wide range of approaches to ensure each term of reference was addressed. Each aimed to optimise the quality of information sought by the expert panel to ensure a robust evidence-base for their recommendations.

The approaches included:

1. **Desktop exercises** to consider the previous reviews and the recommendations from the INI and the observations from the USI and what happens regionally across the UK.
2. **Data collection** from HSC organisations on their MHPS cases since 2017.
3. **Written submissions from** regulatory bodies and trade union organisations.
4. **Deep dive engagements** with HSC organisations, regulatory bodies, and trade union organisations.
5. **Written engagement** with medical and dental professionals who had been subject to the MHPS process to learn about their experiences, and how they could be improved.

3.1 Desktop Exercises

The Independent Review Panel carried out a desktop research exercise considering the work that had been carried out previously to review MHPS and the recommendations from the INI and observations from the USI. They also considered how other jurisdictions in the UK handled concerns.

3.2 Data collection

The Independent Review Panel issued a data collection questionnaire to all HSC employing organisations. A copy of the questionnaire can be found at Appendix D. This asked for information covering 2016, 2017, 2018, 2019 and 2022. The review panel decided to exclude the main “Covid years”. The data that was collected covered the makeup of the cases each year.

Stakeholders were asked to provide any commentary on factors that caused delay and how they could be avoided or mitigated. In addition, they were asked to comment on what factors lead to lengthy/indeterminant exclusions and how these too might be avoided or mitigated. Stakeholders were also asked to comment on any issues where

the involvement of NHS Resolution's Practitioner Performance Advice (PPA) including where this did not facilitate a prompt or satisfactory conclusion and how this could be avoided or mitigated.

3.3 Written Submissions

The Independent Review Panel wrote to regulatory bodies and trade union organisations asking them to submit their views on three main issues:

- Their views on the need to have a Northern Ireland Framework for managing concerns that sits alongside local Trust policies and procedures.
- Their view on what the issues are with the current MHPS process(es).
- Their suggestions on how the issues might they be improved.

3.4 Deep dive Engagement with organisations

Engagement sessions were held with various stakeholder groups. A full list of those engaged with can be found at Appendix C.

These sessions took place both face to face and online in October, November & December 2023 and provided an opportunity for the organisation to expand on their involvement in the MHPS process and for the Review Panel to obtain more in-depth understanding on organisation's view on MHPS. Each session covered similar topic areas, primarily addressing:

- The need for MHPS.
- The need for appropriate support within the MHPS process.
- Issues with the MHPS process; and
- Improvements required within the MHPS process.

All engagement sessions were well attended, and all those present contributed to the honest and fulsome discussions. This allowed the review panel to gain a good understanding of the issues with the current MHPS process and suggested improvements.

3.5 Engagement with medical and dental professionals

It was decided the best method of gaining access to this stakeholder group would be via their employing organisations issuing written correspondence on behalf of the Review Panel to all individuals who have been subject to the MHPS process since 2016. The letter asked the individual to respond to the project team if they would be willing to engage. This way the Project Team and Review Panel were not being provided with the names from employing organisations for direct initial contact and therefore ensuring confidentiality of these individuals and inviting them to contact the review in the first instance.

Thirty-one practitioners registered their interest to engage with the panel. The panel devised a short questionnaire to aid in the gathering of their experiences. A copy of this questionnaire can be found at Appendix E. An invitation to complete the survey was issued to all and seventeen responses were received.

4 Findings

4.1 Overall findings of the independent review panel

4.1.1 Summary of analysis of data provided.

The document *Maintaining High Professional Standards in the Modern HPSS - A framework for the handling of concerns about doctors and dentists in the HPSS* (MHPS)[6] was issued by the then Department of Health, Social Services & Public Safety in November 2005. It was issued under cover of Departmental circular HSS(TC8) 6/2005 which advised (then) HPSS organisations of their obligation to comply with the framework under the *Direction on Disciplinary Procedures* (2005). The circular also advised that the framework replaced four pieces of guidance, dating from 1975 – 1995, concerning various aspects of disciplinary procedures, suspension and avoidance of harm to patients. Each of these applied exclusively to hospital and community medical and dental staff.

The Framework was developed to contribute to and complement wider governance processes focussed on assuring the quality of health services, termed clinical governance. It was also intended to address issues with the extant processes for managing concerns about doctors' and dentists' performance. A particular concern was the fact that procedures had the potential to fail in reaching a definitive conclusion resulting in medical and dental staff being excluded from practice for lengthy periods of time. In addition to the on-going salary costs and the negative impact on the individual, this approach has the potential to lead to the deskilling of the individuals involved, undermining the ability to return to work, and the erosion of mutual trust and confidence between employer and employee.

It was envisaged that the new arrangements introduced in 2005 would bring about a consistent process for handling concerns about the performance of doctors and dentists, aiming to adopt a remedial approach to such concerns wherever possible rather than an exclusively disciplinary approach. Whatever the source of a concern, the response was expected to be the same –

- to ascertain quickly what has happened and establish the facts.
- to determine whether there is a continuing risk.

[6] https://www.health-ni.gov.uk/node/69104

- 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.

4.1.2 Data from HSC employing organisations.

MHPS is applicable to all HSC employed medical and dental staff in Northern Ireland. As set out in the methodology, employing authorities were surveyed to gauge the frequency of use of the procedures set out in the document, their outcome and the time taken to complete various aspects of the procedures. It should be noted that the data returned by employing organisations on the application of MHPS were incomplete, limiting the conclusions that can be reached, with one organisation providing no data prior to 2017 and no outcome data for any year surveyed. Another did not record the number of informal cases until 2022. All responding HSC employing organisations conceded that recording the informal stage of the process was inconsistent.[7]

Not surprisingly, the largest Trust in Northern Ireland, which employs approximately 40% of this staff group, declared in their survey return, to have the most informal cases in any calendar year, varying from 2 -19, with an average of 13 across the period surveyed. This contrasts with the other trusts, where the range of cases annually varies from 0 – 7, with the most common annual number being zero. Over the period surveyed, 35 cases where the “informal approach” was adopted reached a conclusion and an outcome was recorded. In 28 of these cases (80%) the approach resulted in no further action or an internal (non-disciplinary) intervention.

Perhaps to be expected, the number of formal investigations is considerably smaller with no HSC employing organisations initiating more than 5 cases in any given year, with zero cases being the most common number in any one year. Of those formal cases completed with a recorded outcome two-thirds (24) resulted in formal disciplinary procedures or referral to the regulator and of note, 4 cases resulted in no further action.

[7] Appendix G details all data provided by HSC employing organisations.

Regarding exclusions, these are the most completely recorded element of the processes covered by MHPS, with 11 occurrences over the survey period. Again, numbers across individual organisations are low, with no HSC employing organisations initiating more than 2 exclusions in any given year and, most commonly none. HSC employing organisations were able to provide data on the duration of exclusion in 8 cases, indicating that 5 of these exclusions lasted between 6 and 12 months. Related to the issue of exclusion, engagement with the Practitioner Performance Advice (PPA) service of NHS Resolution was frequent, with an average of 28 in the period 2018 – 2022, which corelates in accordance with PPA's annual reports on caseload in the HSC.

Diagram 1 detailing the breakdown of cases by concern as reported by HSC employing organisations from 2016 – 2022 (excluding 2020 and 2021 due to covid)

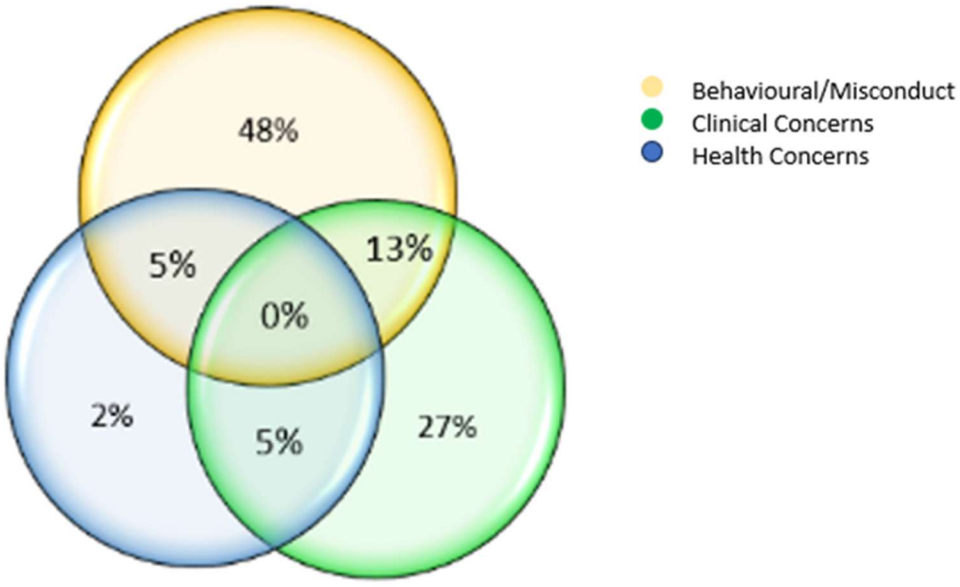

Diagram 1 shows the MHPS cases broken down into the three main categories, where returns provided a categorisation.

As can be seen from the above diagram, the majority of cases (66%) have a behavioural aspect, with nearly 50% of cases exclusively behavioural/misconduct. 45% of cases reflect a clinical performance concern and 12% have a health element.

These proportions are broadly in line with those produced by PPA on its activity in the HSC.

4.2 Finding 1 – The purpose of MHPS.

The first question that should be considered is 'What is the purpose of MHPS'?

As set out in the context, one factor leading to the development of MHPS was concern that, rather than definitive actions, the then extant procedures had the potential to fail to reach a definitive conclusion, resulting in some cases with on-going lengthy suspensions.

The introduction to the document gives some indicators regarding the purposes of the document.

[Introduction - Paragraph 6] *"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."*

[Introduction - Paragraph 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."* (our emphasis)

[Introduction - Paragraph 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 were deemed appropriate".*

The panel concluded that these aims seem to have been lost in the remainder of the framework and its application. One possible reason for this is the absence of a clear statement of the changes MHPS introduced. These are set out in the analogous document for the NHS in England. This is ironic, given the significant replication of the MHPS for NHS England document throughout the bulk of MHPS for the HSC. The pre-amble to the MHPS for NHS England document stated:

"The key changes are that:

- *the distinction between personal and professional misconduct is abolished. Doctors and dentists employed in the NHS will be disciplined for misconduct under the same locally based procedures as any other staff member;*
- *there is a single process for handling capability issues about the practitioner's professional competence closely tied in with the work of the National Clinical Assessment Authority;*
- *Health issues are routinely dealt with through the occupational health service;*
- *The employing Trust is squarely responsible for the disciplining of its medical and dental staff – not outsiders;*
- *There is scope (to) bring in expert advice for panels considering capability issues;*
- *The capability panel will be handled by an independent chair;*
- *The same disciplinary procedures will apply to all doctors and dentists employed in the NHS."*

In summary, the primary purpose of the document was, that once a concern regarding a doctor or dentist's practice is identified, there should be processes in place that deal with the concern, largely without recourse to formal disciplinary procedures. The data surveyed from HSC organisations would suggest some degree of success in this regard. More than twice as many cases are dealt with informally as formally. Of the informal cases, 80% result in no action or mutually agreed action plans. Formal cases result in disciplinary sanction or investigation by the professional regulator in the majority of cases, although approximately 1 in 6 results in no further action. This suggests the "informal approach" acts as a reasonable screen for more serious cases.

Exclusion is a relatively rare event but tends to be lengthy, typically lasting up to 12 months. This suggests the policy has been less successful in reducing lengthy exclusions.

4.2.1 The Status of the Document

Critical to fulfilling its purpose is the nature of the document. Is it a framework (as termed in its title) setting out key principles to inform local organisational processes? Is it guidance on the detail of local procedures? Or is it a collective process masquerading as a procedure?

The panel felt that unfortunately, whilst the intention appears to be the first of these it exhibits many features of the others, which can only undermine effective implementation. This is perhaps not surprising as it is the result of a negotiated/collective agreement (with all that this entails). The net result of this is that in different parts of the document it sets out broad principles as would a framework, elsewhere it sets out more detailed procedural guidance and at other points sets out the rights and responsibilities of various parties. What the past has shown is that such collective agreements lack the necessary precision of a procedure because they are predicated on compromise rather than operational efficacy.

However, some key principles and unequivocal statements appear early in the document, that represent sound principles for a future document. Among these are:

[Introduction - Paragraph 5] *"Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist".*

[Section I – Paragraph 1] *"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,"*

[Section I – Paragraph 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."*

[Section I – Paragraph 16] *"The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone".*

The review panel believe the purpose was intended to be a guiding framework through which HSC employing organisations developed their own local procedures. However, this purpose was undermined by the latter sections setting out detailed procedures.

4.2.2 Treating employed doctors & dentists differently to other HSC employees.

Another key element of the document, relevant to its purpose, is its exclusive application to a sub-set of HSC staff –doctors and dentists employed by the HSC. The continued need for bespoke arrangements for these staff groups was a fundamental question for the Review and was asked of every group the Review Panel engaged with.

Arguments for separate processes were that doctors and dentists are highly trained individuals who are difficult to replace and, as registered practitioners, actions by the employer have the potential to be career ending. The panel was not persuaded by these arguments, given that a sizeable proportion of other HSC staff are subject to professional regulation; notably nurses who represent 30% of non-medical (and dental) staff. Others include pharmacists, social care workers and all those regulated by the Health and Care Professions Council. All of these are subject to generic disciplinary conduct, health and capability procedures. For all these registrants, their career is also at stake when their registration is in question, ultimately an issue for the regulator not the employer. Arguably, effective local procedures that are applied early in the evolution of concerns, resulting in proportionate and effective interventions should lessen the likelihood of referral to the regulator with the potential for career threatening consequences.

In addition, in comparison with 2005, there are many more health professionals (whether graded as consultants or not) with a degree of autonomy in therapeutic decisions, frequently in the context of care provided by a multi-disciplinary team which includes medical and/or dental staff. In this context, it is questionable that one staff group within a team should be subject to differing processes when issues regarding their individual performance are raised.

This is particularly true with regard to issues of conduct and behaviour, the most common aspect of performance dealt with through the “MHPS process”. Appropriate conduct is set out in the *Code of Conduct for HSC Employees*, published in November 2016. This applies to ALL HSC employees and is compatible with relevant professional codes of practice. Since September 2022, allegations relating to breaches of the code are dealt with through the Regional Disciplinary Policy and

Procedure. The panel were disheartened to learn that this policy has yet to be fully adopted by all HSC employing organisations and this is a matter of concern.

Nor does the scope of the Policy extend fully to medical and dental staff, as it states, *"The only exception is Medical and Dental Staff, where concerns about their conduct are handled through the "Maintaining High Professional Standards Framework" until a decision is made to progress to a conduct hearing under this disciplinary policy".*

Whether this addresses MHPS' statement that *"Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist."* (Introduction Paragraph 5) is debatable but it seems unduly bureaucratic that addressing a concern should be subject to separate processes at different stages.

4.2.3 The Structure of the Document

Throughout the Panel's engagement exercise, a universal comment related to the document being difficult to follow, cumbersome and contradictory in parts. In the panel's review of the document, one section illustrates these issues most starkly, *Section I, Action when a concern first arises*. This section does not confine itself to initial actions, as the summary below (Section 1 - paragraph 4) illustrates.

"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."*

Whilst the first four points are entirely appropriate, it appears premature to introduce the remainder at this stage and clearly contributes to the perception that this process is formal from the outset. This is compounded later in this section where various roles are designated, 11 paragraphs are devoted to the formal approach in contrast to 3 for

the informal. Most problematic is that the conclusions on next steps appear at the end of the formal approach (based on a case investigator's report), and it is questionable whether some of these are appropriate or achievable as part of initial action. Inevitably, confusion over initial actions will undermine any subsequent actions.

Two employing organisations have sought to address this problem through the introduction of their own tailored guidelines for handling concerns about doctors and dentists. Whilst referencing MHPS, they draw heavily on The National Clinical Assessment Service (NCAS) document: *How to conduct a local performance investigation*, published in 2010. Key elements in the NCAS document are the need to conduct an initial screening based on readily available information, the need to document any actions and the need to keep the practitioner informed and supported throughout. Notably, adopting this approach, one Trust has been able to complete the screening process within 4 weeks and reached agreed actions with the practitioner in a high proportion of these cases as indicated in their response to the panel's survey.

The screening element contained in the local guidelines are essentially identical to that described in the aforementioned regional disciplinary process. As such, the panel are of the view that the regional disciplinary process should be extended to include medical and dental staff. This should be seen as an initial step in the adoption of unified processes for **all** HSC employees.

Recommendation 1 - Medical and Dental practitioners should be subject to the same HR policies that address performance concerns applicable to other HSC employees.

Recommendation 2 - The Regional Disciplinary Policy and Procedure should be amended to include Medical and Dental staff from the initial raising of a concern. Its universal adoption by all HSC employing organisations should be mandated by the Department.

Recommendation 3 – The Regional Disciplinary Policy and Procedure should be used as a template to develop a separate regional document to address capability issues which applies to all HSC staff including medical and dental staff and its universal adoption by all HSC employing organisations should be mandated by the Department.

Recommendation 4 - The Regional Disciplinary Policy and Procedure should be used as a template to develop a separate regional document to address health related performance issues which applies to all HSC staff including medical and dental staff and its universal adoption by all HSC employing organisations should be mandated by the Department.

4.3 Finding 2 – The Process

4.3.1 Formal v informal

The panel questioned whether “formal” action should be part of the initial response to a concern and agreed that any interaction between an employer and employee (or someone acting on their behalf) is never informal. However, invariably organisations’ HR policies rightly require an interaction between the individual employee and their line manager in an endeavour to secure an ‘informal resolution’. This usually follows some initial evidence gathering by the line manager that focuses on the concern not the individual with the aim of mutually agreeing a SMART action plan if necessary to address the issue arising and to set out the consequences if the actions are not achieved.

The INI encapsulated this well (Volume 3, page 196, para 13.45[8])

"(iii) *The intricacies of the Maintaining High Professional High Standards (“MHPS”) procedures make dealing with doctors in difficulty a more cumbersome process than should be the case. Good management can and should filter out issues which need not be formalised. Nevertheless, an informal process such as the one which operates within MHPS, must be robust and well documented. The present informal process within MHPS is opaque and often leads to different doctors taking widely different approaches to investigation. Informal processes are sensible and the managerial norm, but they must be coherent. It is recognised that a critique of the MHPS procedure is, of itself, a significant and discrete piece of work, which is beyond the scope of this Inquiry. The Inquiry Panel does wish, however, to place on record its view that reform of the existing procedure is long overdue. The present balance of the procedure is weighted towards the protection of the doctor and in the confidentiality of the process rather than patient safety*.”

This broadly accords with the Review Panel view, that a significant number of these ‘cases’ can and should be dealt with through day-to-day management and are cognisant that all grievance and disciplinary policies in the public sector have an informal approach embedded in their procedures. This at times creates practical

[8] https://www.neurologyinquiry.org.uk/sites/ini/files/INI%20Final%20Report%20-%20Volume%203%20-%20June%202022.PDF

problems in terms of matters being recorded or expressed in writing or held on file, for whatever purpose, tends to bring formality to the informal thus blurring or at times eradicating the demarcation between informal and formal approaches. Such lack of clarity can often result in the informal approach being defunct or indeed subsumed within the formal approach thereby rendering it redundant and becoming a source of tension.

Within the context of MHPS a combination of both language and practice has provided the contextual backdrop for the informal approach to be rendered ineffective and leave little or no scope for what would be best described as day-to-day line management especially regarding the opportunity to address inappropriate behaviour at an early juncture.

The panel believe that disproportionate use of MHPS, particularly where the formal element is invoked, speaks to both culture and capacity within employing authorities and may be an indicator of the degree of cultural openness and fairness. Whilst, as indicated earlier, the majority of cases are dealt with through the informal approach, in some organisations the reverse is true. As set out in the previous section, some organisations have developed a "work around" drawing on the screening element set out in the regional conduct procedures for other staff.

A "screening" approach is in line with the regional conduct procedure and NCAS guidance of 2010[9]. This document states [Paragraph 1.2] *"Regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. Anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.*

The form that screening takes will vary from organisation to organisation. The essential requirement is that a consistent process is followed, with decisions made by a person or group with appropriate authority.

Decisions made should be appropriately recorded and the practitioner kept informed of progress.

[9] https://resolution.nhs.uk/wp-content/uploads/2019/03/How-to-conduct-a-local-investigation.pdf

The purpose of screening is to identify whether there are prima facie grounds for an investigation.

"The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself."

It is the panel's view that the initial stages of the process specified in MHPS should be considered an integral part of day-to-day management, rather than the initial stage of a prescribed (inevitably formal) process. However, given the nature of medical and dental management (see later), line managers should be able to draw on support in the initial evaluation of a concern. As previously advised, two employing organisations introduced their own tailored guidelines for handling concerns about doctors and dentists. Both sets of these local trust guidelines point to support from senior HR personnel at this stage, something the panel supports unequivocally.

It is anticipated that, at the conclusion of the screening process, a clear course of action will be determined in the majority of cases. Inevitably, there will be occasions when the screening process is not conclusive, and a more involved fact-finding exercise may be warranted.

A further issue with the use of the term 'informal' relates to the rigour with which this stage of the process is carried out. As referred to in the general findings, this manifests itself in a number of ways and result in an inconsistent approach to:

- recording that the informal approach has been applied.
- documenting the information gathered.
- recording the decision and the rationale for that decision.

At the most obvious level, one employing organisation did not record the number of "informal" approaches until 2022 (when prompted by this review's survey) and others advised they could not be sure that they had maintained a complete record of such cases which contributed to the panel's doubt as to the integrity of some of the data submitted by organisations as part of this review.

All stages of managing a concern must be documented. In the event that a doctor or dentist has their employment terminated and the issue becomes the subject of litigation, the industrial tribunal in NI has jurisdiction to make a ruling regarding the fairness or otherwise of the decision to terminate. Upon a very straightforward analysis

the decision will examine the procedural correctness and substantive fairness of the decision to terminate the employment.

Each case will turn on its individual facts and merits and quite often such fact sensitivities will have a significant impact on the eventual decision of the tribunal. Such fact sensitivities could include:

- The existence of procedural flaws in the MHPS operation and application
- The duration of the process (i.e.) being unduly protracted
- Those operating the process lacking in skillset or awareness of core principles underpinning the process.
- A lack of substantive fairness regarding matters such as duration of exclusion or conflation of conduct with capability
- The complications posed by other jurisdictional matters being raised around health and safety, whistleblowing, protection from harassment or other jurisdictional matter.
- The existence of other legal processes running simultaneously to tribunal proceedings such as High Court actions relating to permission to seek injunctions or breach of contract.

Whilst dismissal, high court action and industrial tribunal proceedings are relatively rare, they can be obviated at best or a credible defence mounted at worst, if proper process is adopted from the initial raising of a concern. This feeds the necessity for accurate record keeping and well trained and experienced staff applying procedures appropriately. The need for adequate documentation is particularly important for doctors/dentists as some professional managers are in post for limited periods with short tenure, which then acts as a hindrance to operational efficiency in investigations especially where identification of patterns is undermined due to changes in management. The reliance on the corporate memory of an individual rather than having a consistent presence to identify patterns of behaviour has proved problematic and needs to be addressed through record keeping in order to identify pattern development.

A further key consideration necessitating adequate documentation, as detailed earlier, relates to the role of the Responsible Officer (RO), especially their recommendation on revalidation of individual doctors.

The GMC advises thar *"RO's recommendation must be based on, their knowledge of the individual doctor's compliance with GMC's requirements, and all information available to the RO about the doctor's whole practice from appraisal and other local assurance systems".*

Clearly the documentation of concerns and how they are addressed are intrinsic to the Responsible Officer discharging their role in a fully informed way.

4.3.2 Sharing of information with the RO.

Any replacement of the 2005 MHPS framework must include the necessity to share information relating to any investigations and/or questions regarding a doctor's performance in any scope of work with their RO as this may affect the latter's recommendation as to whether or not to recommend the doctor for revalidation. During the Paterson inquiry it was identified that the there was a gap in information sharing between the NHS and private healthcare sector that resulted in Paterson being able to practise for longer than he should have with devastating effect.

In addition, the sharing of information needs to be reciprocated as if a GMC Medical Practitioners Tribunal Service has imposed conditions on the doctor's registration or if the doctor has agreed undertakings with the GMC, the RO is responsible for assuring the GMC that the doctor is complying with the requirements imposed on them. The RO will therefore need to share information with all those responsible for day-to-day clinical oversight across the doctor's scope of work.

In the event that a doctor's practice has been found wanting by the employing (or contracting) organisation, the RO can also be instrumental in requiring the doctor to engage in an enhanced appraisal and this requires a second level of information sharing beyond the RO as the RO will need to share appropriate information with the nominated appraiser to enable this to take place. In this regard, the explicit link in any replacement to MHPS to the RO regulations will enable the statutory framework for doctors to be more robust to maintain patient safety and support doctors in any intervention.

4.3.3 Exclusions/precautionary suspensions

In the event that a concern is raised as to whether the actions of a doctor or dentist has the potential to expose patients to risk of harm it is essential that a risk assessment of the information is undertaken to inform what if any action should be taken. Sometimes, the concern raised may extend beyond the potential for harm to patients to harm to the practitioner, the team or the employing organisation and the risk assessment should consider these factors. This is particularly so for senior doctors given their autonomy and leadership role whilst treating patients and whilst leading a clinical team. Inevitably in some circumstances the need to invoke a precautionary exclusion from the workplace as a last resort will prevail. Whilst this is good practice this action is serious albeit it is couched as a 'neutral act' whilst a fact-finding exercise is undertaken. It is not a decision or imputation of guilt or liability; however, this action inevitably can have a significant impact on the practitioner which ranges from a feeling of fait accompli through to serious adverse mental health ramifications and whilst in place has the potential to erode the implied duty of trust and confidence between the employee and employer. Such harm is worsened by a protracted process. The review panel reminded themselves that this was one element giving rise to the introduction of MHPS.

The review panel heard unanimous agreement from stakeholders that the time taken to conclude both formal and informal investigations from start to finish is hampered by the lack of capacity and the myriad of foreseeable delays that can manifest during an investigation. This is often overlaid with delays that are introduced when the practitioner reaches out for advice and support from legal representatives. When the practitioner is also subject to a precautionary exclusion, such delays have the potential to result in isolation of the practitioner and deskilling which can have a detrimental effect on the practitioner's future career. These issues together with a plethora of other fact sensitivities mean that precautionary exclusions as with delays, can often become the focus of attention and the greater the duration the more likely it is that this can influence parties' "next steps" meaning that the internal process can be superseded by other actions such as litigation, resignation, inquiry, or injunction thereby changing the entire dynamic and potentially the end result.

Updated guidance on the considerations and actions necessary for exclusion/restriction which is clearly separate from disciplinary procedures may lessen the perception set out above. Possibly of greater value in these cases, would be a clearly documented case, setting out the safety issues at play, how the practitioner's presence has the potential to impact negatively on these and the options to address these, sharing with the practitioner with a view to agreement on the appropriate action. The NCAS document on conducting a performance investigation sets out how this might be achieved.

Allied to these will be the need for a continual review of the appropriateness of the suspension / exclusion, regular and documented communication with all parties involved in a bid not to compromise the trust and confidence of the practitioner.

However, most critical to preventing escalation within the process is ensuring timely progress towards a definitive end point is expedited.

4.3.4 Timescales

A universal comment received by all those the Review Panel engaged with was the inability to meet the timeframes set in MHPS, particularly the need to complete a report on the informal stage within 4 weeks. The document frequently cites deadlines for various elements of the process. The single most contentious of these is the requirement set out in Section I, para. 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."* Universally, this timeframe was considered impossible to achieve, for a variety of reasons, not least the lack of dedicated time for the case investigator and the availability of witnesses.

Analysis of organisations' returns bears this out. Notably, however, those employing organisations who have developed local guidance which includes an initial screening element have enjoyed greater success in meeting this timeframe. Even allowing for this, of 96 cases, only 27 were completed in less than 3 months. with a third taking longer than 6 months.

Various reasons were cited which contribute to prolonging this stage of the process, notably time taken to access and collate relevant information, limited understanding of

the process, staff availability to contribute either as witnesses or support the work involved. Other factors included the involvement of external agencies and their representatives, counter claims and pending litigation.

In the case of the formal approach, only four employing organisations recorded the time taken to complete cases. In these, few were completed within 3 months, with more than half taking at least six months to complete. Relevant issues raised in addition to those prolonging the informal stage included the availability of trained investigators, generating and sharing evidence in a complete and timely manner and HR capacity to support the process.

The panel is fully cognisant that procedural delays and the challenges of adhering to the procedural timetables for the completion of formal processes is commonplace throughout the public sector in Northern Ireland. Indeed, so commonplace is this fact that it is almost implied between all parties to the process that the first casualty shall be the completion date for the process. Procedural delays are virtually normalised for a variety of eminently foreseeable reasons ranging from – stress related absence and unavailability as a result, inability to co-ordinate diaries, interjections from representatives, processes being conflated/overlapped, data subject access request and counterclaims in areas such as bullying or whistleblowing.

Nothing in the above list is new or unique to the public sector in Northern Ireland but it is clear that within the context of MHPS delays in procedure are the basis of wholesale dissatisfaction for all parties to the process. Indeed, the longer the delay the greater the impact on the mutually applicable implied duty of trust and confidence and as the delay continues the focus draws away from the subject matter at the heart of the process and instead the focus shifts to the impact of the delay.

Whilst there will always be consensus over such process needing to be completed promptly and in accordance with a stipulated timeframe there is often a reluctance to attach a definitive timeframe and perhaps this is based on experience, the need to have some built in flexibility using expressions such as “within a reasonable timeframe”.

Frequently cited throughout the current document, particularly Section II, are essentially reviews of exclusion on a four-weekly basis, with specific actions at

different stages. Repeatedly, comment was made regarding the limited value of these actions, particularly in cases of police or fraud investigations.

A further point was the need to report to the Department at various stages. Whilst this might have been necessary in 2005, given the intention to eliminate lengthy exclusions, data suggests these are relatively rare now.

Stakeholders that represented doctors and dentists reported that employing organisations did not dedicate sufficient time to manage concerns effectively and cited lengthy investigations that breached the 4-week timeframe laid down in MHPS. The review panel were of the view that the 4-week timeframe set out in MHPS was unrealistic and breaching it was inevitable. Notwithstanding this, in reviewing the data collected from employing organisations at the outset of the review, it is evident that the time taken to conclude some investigations is excessively lengthy and shorter timeframes should be actively pursued.

The wider public sector in Northern Ireland have found that prescriptive timeframes have the effect of shifting the focus of the process towards functional timeliness rather than substantive subject matter and invariably when timeline targets are missed then this sets the tone regarding perceived process dysfunction. As a result, many organisations couch their process completion objectives in terms of being prompt, timely and without undue delay rather than a prescribed number of days.

It is clear to the review panel that the timescales set out in the MHPS framework are not achievable and given the issues highlighted in this report, managing cases and investigations are not always completed in a timely manner. There is also a tendency to defer to MHPS process when other processes such as whistleblowing are made thus further lengthening these timescales.

4.3.5 Overlap / interaction between procedures.

An issue that provides a constant challenge to the operation of any dispute resolution related policy document in the public sector in Northern Ireland is where it has an overlap or interaction with a related policy document.

Such cross-cutting matters are reasonably foreseeable but invariably provision is not made for things such as clarity on the impact of one policy or procedure being invoked whilst another is in mid-progress.

As MHPS was written as a de facto collective agreement not specific to an individual employer the cross referencing to any HSC employing organisation policies that could interact or overlap is non-existent and so no provision for how such interaction would impact on MHPS or related policy document is made.

Based on the panel's findings regarding MHPS perhaps the most commonplace interaction is the invocation of a public interest disclosure / whistle-blowing procedure whilst an MHPS investigation is underway. The relevant legislation in this area is the Public Interest Disclosure (NI) Order 1998 and it is designed primarily to provide retrospective remedy against detriment or dismissal for a worker who has made a protected disclosure as defined and provided for in the legislation.

Such is the prevalence of whistle-blowing concerns being a feature of MHPS operational proceedings that the panel can perceive a discernible pattern which has the net effect of:

- Questioning the timing of the invocation of such a procedure
- Becoming a chosen route for a de facto counter-grievance
- Stymieing all or part of the MHPS process
- Formalising a potentially informal process
- Increasing the adversarial culture of MHPS processes
- Creating the basis for predictable litigation routes to industrial tribunal or High Court

The lack of clarity of where MHPS sits in relation to policies such as a regionally agreed dignity at work procedures also provides the basis for confusion regarding policy interaction especially regarding those related to behavioural interaction between HSC employees.

The panel recognise that the net outcome regarding policy interaction between MHPS and other "related" policy documents is underpinned by operational obfuscation and as such needs to be rectified. It is reasonably foreseeable that invoking a policy in the midst of another policy being followed can be the grounds for confusion around things such as – putting one or other of the policies into abeyance, duplication of investigatory processes, elongating the processes which can be exacerbated by participants being unavailable on stress related absences or other such reasons.

There are issues with the overlapping of procedures (for example counter grievances, dignity at work, whistleblowing complaints) in terms of – which policy or procedure should take priority, which ones can run concurrently, which ones need to be put into abeyance and which have been subsumed by the other. There should be clarity of purpose as opposed to a hierarchy of priority procedures in order for due process to run its course. The skills and competence of those carrying out the investigation should be able to proceed or seek guidance from relevant parties or organisation.

It was noted that with the plethora of policies and procedures in place for employed members of staff, case managers and HR managers felt challenged in their knowledge about which policy should be applied to the given circumstance particularly whether they should be using MHPS or local policies for managing conduct and health issues. It was noted that all stakeholders agreed that there was a need to build managers capability to deal with issues as they arise. It was noted that those managing concerns for other staff were able to follow a simpler process and that the development and adherence to the Regional Disciplinary Policy and Procedure published in June 2022 was helpful.

To some extent the Labour Relations Agency publication, *Conducting Employment Investigations* (2016)[10] is also helpful [page 13]

"The investigator should also pay due regard to aspects of good practice…

Familiarise yourself with your policy if there is a criminal element to the nature of the alleged offence. In other words, does the organisation automatically defer to the police and put any internal investigation into abeyance until the police have concluded their investigation regardless of the nature and seriousness of the alleged criminal offence? For example, if £10 is stolen from petty cash is an internal investigation impossible until after the involvement of the PSNI?

Familiarise yourself with the grievance and disciplinary policies to see where and how investigations fit into these.

[10] https://www.lra.org.uk/sites/default/files/2019-03/Advisory%20Guide%20-%20Conducting%20Employment%20Investigations.pdf

Ensure that, where the investigation is on bullying or harassment, the investigation procedure complies with any Dignity at Work policy in terms of things such as protection of victim, precautionary suspensions, and compliance with timescales.

Be prepared for things such as data subject access requests being made, by those involved in the investigatory or grievance or discipline process, under personal information rights afforded by the Data Protection Act (1998).”

In short there is no one size fits all, but a need for knowledge of potential for these things to be brought up and appropriately dealt with is required. The panel were of the view that a performance investigation should not automatically be put into abeyance when these issues are raised. However, this also points to the need for a cadre of staff who are knowledgeable in the range of procedures that may impact on the handling of a performance concern and the broad principles that can be applied to ensure timely progress towards reaching a definitive conclusion regarding the concern.

4.3.6 Capacity within the process

All stakeholders articulated the need to ensure adequate capacity of all members of staff who manage concerns within employing organisations to ensure that the process is managed efficiently and fairly. The need to be assured of this extended beyond case managers and case investigators to decision makers and the non-executive member charged with oversight of the most complex cases. With these two key components in place, stakeholders were of the view that the process is less likely to be adversarial and outcomes more achievable to remedy. The panel agreed they are key enablers and might help mitigate the protracted and adversarial nature of these procedures.

Employing organisations were unanimous in their view that the absence of a dedicated appropriate resource to undertake investigations and other processes associated with fulfilling the MHPS process hindered the efficiency of managing concerns in a timely manner and impacted on the actual or perceived fairness of the process.

Within the HSC employing organisation HR community, it was reported that HR teams also need to be adequately resourced to provide the appropriate level of support to their clinicians who are leading the work, noting that HR struggle with using MHPS as

the small number of cases within individual organisations limits the ability to develop a degree of expertise in its application.

In addition, those tasked with the identification and management of concerns appear ill equipped to deal with these matters in a timely and definitive manner due to a variety of factors including, lack of dedicated time (particularly the unpredictability of the type and volume of cases that arise), limited (usually one-off) training, limited organisational support, and a mixture of unwillingness/reluctance/anxiety as evidenced in the transcripts of the USI. These factors are compounded by a lack of awareness of sources of information which might inform a management decision, complicated by a sense that some of these pieces of information are “confidential” or privileged. The panel also surmised that ‘fear’ arising from potential lack of competence/confidence compounded when there is legal representation or a Subject Access Request, and this can then change the way in which a case is managed which in itself introduces different procedures and potential delays. Again, as referred to earlier, if seen in the context of supporting the RO role (and its statutory basis), misgivings over the latter should be dispelled.

Stakeholders that represent doctors and dentists told the review panel that they saw significant variation in processes and outcome across HSC employing organisations and expressed views that staff involved in the management of concerns needed training or retraining and in some circumstances that they had concerns regarding the quality of reports with one stakeholder citing a lack of confidence in one organisation in this regard.

The review panel concluded that amidst other factors already referred to that the lack of volume of cases in organisations has resulted in a lack of familiarity with the associated processes and an inability to build and maintain appropriate skills and expertise It was the view of the panel that given the nature of these cases and the potential adverse impact of their inefficient management, a dedicated resource was needed to manage these cases effectively. However, given the number of cases per year in each employing organisation, it would be difficult to sustain a viable team of suitably skilled individuals in each organisation.

4.3.7 Confidentiality

Confidentiality as a concept and descriptor has grown exponentially over the years in the public sector and as such now goes beyond the simple expression relating to the protection of personal information. In the public sector in Northern Ireland confidentiality can operate as a de facto blanket ban on any disclosure in any context.

To this extent vagueness around confidentiality and disclosure means that it can be used as a sword or shield in equal measure and as such the impact on issues addressed under the problem areas identified in the previous section on "overlap and interaction between policies" are exacerbated as confidentiality provisions may prevent one policy "speaking" to another. It is for this reason that the panel examined confidentiality within a context.

MHPS refers to confidentiality on four occasions.

(Section I para. 31) "*The Case Investigator: …*

must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality needs to be maintained."

This appears entirely reasonable within the context of an investigation.

(Section II para 39) "*Employers must maintain confidentiality at all times and should be familiar with the guiding principles of the Data Protection Act."*

As Section II is concerned only with exclusion and restriction of practice and, in this context, again appears reasonable.

(Section V para 4.) *"On referral to OHS, … Confidentiality must be maintained by all parties at all times."*

As this section is devoted to health matters, the confidentiality of a patient's personal health information applies.

Given that there have been developments in areas of the law on data protection and governance provisions regarding transparency of process the panel is conscious that provisions regarding contextual and qualified confidentiality need to be both proportionate and more specific and not operate in such a way as to be obstructive to the fair and reasonable operation of any due process.

A further legislative requirement not referenced by INI is under "*The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*[11]*, which introduced the duty of quality and 34.— (1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—*

(a)the health and personal social services which it provides to individuals; and

(b)the environment in which it provides them."

The INI gave specific recommendations in relation to the conflict between patient safety and confidentiality.

The legal opinion sought from the inquiry on retention of complaints material in light of GDPR and other legal requirements concluded *"There is a specific obligation to investigate concerns raised by patients or staff; and to record the details of what steps are taken. Our starting point is that any information raising legitimate concerns about patient safety is entitled to be retained for so long as it may be relevant to the protection of patient safety. In general terms, this is likely to be for so long as the relevant clinician remains in practice and treating patients. The Inquiry Panel strongly agrees. If patient safety is to be paramount and trends are to be identified, then relevant clinical complaints' material should be retained throughout a doctor's career.*

It was universally acknowledged by all witnesses to the Inquiry, that patient safety should be the paramount concern and the standard by which governance and systems are assessed.

Critical information at key times was not passed on to the Belfast Trust by the Ulster Independent Clinic. The information may have altered the outcome of an earlier investigation under MHPS, then being conducted in the Belfast Trust".

The INI noted (Para 61 Volume 1) The over-reliance on confidentiality norms poses real challenges for the evaluation and governance of clinical practice and for any retrospective analysis such as that conducted by the Inquiry.

[11] https://www.legislation.gov.uk/nisi/2003/431/contents

INI Recommendation 16 - The NI Department of Health should ensure that the confidentiality dimension of the MHPS process is always subordinate to patient safety considerations.

INI Recommendation 17 - The NI Department of Health should review paragraph 39 of MHPS and issue guidance on the appropriate balance between confidentiality for the clinician and safety for the patients.

INI Recommendation 18 -The NI Department of Health should oversee the establishment of a group to consider the balance between the fair treatment of clinicians and the safety of patients under MHPS. The group should focus on reducing the complexity of processes and re-evaluating the degree of confidentially. The group would benefit from input from appropriate experts to include Human Resource expertise and Medical Directors.

INI Recommendation 18 has been achieved by the establishment of the Independent Review of MHPS.

Recommendation 5 - Current and future replacement processes must include an initial consideration of a concern that affects an individual's performance whether this arises from a potential conduct, capability or health issue and should involve a screening process. This screening should be part of day-to-day management and should help inform what if any action is required, including whether there is a conduct, capability or health issue or a combination of these.

Recommendation 6 – If at the conclusion of the screening process, a clear course of action has not been determined from the information gathered, Terms of Reference should be drafted for a subsequent investigation. A case manager and case investigator should be appointed at this stage.

The Terms of Reference for an investigation must be shared with the practitioner before the investigation commences. Any information shared with the investigator must also be shared with the practitioner. The investigation report must address and answer the Terms of Reference and be evidence based. The investigation report prepared should set out the context and situation and the findings considered within a band of reasonable responses given these factors.

The practitioner must be given a copy of the report to enable them to comment on any matters of factual accuracy before the report is finalised.

Recommendation 7 – Current and future replacement processes must be fair, open and transparent with the practitioner and the practitioner should be made aware of the initial concern and information available at the outcome of the initial screening process and be given the opportunity to respond.

Recommendation 8 – Employing organisations should identify individuals to contribute to a dedicated pool to support processes (predominately investigations) within individual organisations. Case managers and case investigators must have dedicated time identified and receive on-going training aimed at maintaining a range of up-to-date knowledge, skills and experience.

Recommendation 9 – The justification for any referral to another party must be recorded and should only happen when there is clear evidence that it is necessary to do so to protect the safety of patients, staff or public and or the efficiency of HSC services and the practitioner should be informed of this.

Recommendation 10 - Information must be shared with the doctor's RO and the RO must be kept informed of investigations and/or questions raised regarding a doctor's fitness to practise. Where there are serious concerns raised about a doctor's practice and it is known that the doctor has additional scope of work outside of the primary employing authority, there should be a discussion with the other employing/contracting organisation followed by appropriate information sharing.

Recommendation 11 – If the assessment of the concern indicates a risk to the practitioner and or service and an exclusion or restriction is put in place these arrangements must be reviewed at least every 28 days and the rationale for either maintaining the exclusion/restriction or revoking/amending must be recorded.

Recommendation 12 - Any relevant timescales specified in the relevant policy must be reasonable, promote timeliness and consider foreseeable delays. Any delays should be recorded together with the justification for it. The practitioner must be informed at the earliest opportunity.

Recommendation 13 - Confidentiality should not impinge on patient safety aspects or the utilisation of information, but good information governance should be adhered to, and awareness should be raised on ways of achieving this. The personal data guardian should be consulted as appropriate regarding qualified confidentiality.

4.4 Finding 3 – Roles & Responsibilities and Rights of those involved in the MHPS process.

4.4.1 Roles within MHPS

The Terms of Reference required the review panel to consider the roles specified within the MHPS process. As covered previously, the "designation of roles" (section I, paras 7-9) is at odds with "action when a concern first arises". The review panel is of the view that this is premature as appointment to the roles specified should only occur in the context of a formal investigation (Section I, para. 8) and not during the pursuit of routine management. This requirement may also be at odds with organisational arrangements and individual roles, and it is questionable whether a document purporting to be a "framework" should be prescribing individual designations. Whilst this may have been valuable in 2005, when governance (especially clinical governance) was much less developed, it is highly questionable now. In addition, in 2005, the 17 "HPSS provider" trusts were much smaller organisations than now, when a wider range of sufficiently senior staff are available to undertake these roles.

The individuals that may have a role in the process are summarised below:

4.4.1.1 *The role of the Chief Executive*

MHPS states that for the Chief Executive *"all concerns must be registered with the CE"* which would result in the most senior official in the organisation being advised of all concerns regardless of their seriousness. This is wholly disproportionate, not least because of the breadth of the CE's responsibility, but also as the Panel's survey illustrated, the majority of cases handled "informally" (and a percentage of those handled formally) result in no further action. In any case, the inconsistency with which informal cases are recorded suggest that adherence to this element was patchy at best. A further specified role of the Chief Executive is *"should a formal investigation be required, must ensure that the following individuals are appointed;"*

The designated Board member – *"to oversee the case to ensure that momentum is maintained and consider any representations from the practitioner…"* This requirement may be at odds with the generality of the role which is largely around assuring the accountability of the executive of the organisation.

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."* This may reflect the relatively small size of the then 17 trusts. Similarly, for the Case Investigator *"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 …should, where possible, be medically qualified"* it is questionable whether a framework should be specifying such roles and whether it is necessary for the role to be conducted by a member who is 'medically qualified' when the matter under consideration may be related to conduct. In addition, limiting these roles to medical professionals, given the impediments set out earlier in this report only compound challenges associated with capacity.

It is the view of the panel that the roles identified in the framework are 'over specified' and this gives a false assurance for example that the Board (Chief Executive and NED) have management oversight of cases. The Chief Executive and the NED's role should be of oversight and governance and not operationally focussed. Notifications of individual cases to the Board should be reserved for the most serious issues or those with a risk of coming to the attention of the public or are already in the public domain.

4.4.1.2 *The role of HR*

MHPS states *"the Director of HR 's role will be to support the Chief Executive and the Medical Director."* The nature of this support is itemised throughout the document; involvement in the appointment of the case manager, a case investigator, the need for a formal investigation, advising the Medical Director (as case manager) on the course of action following completion of the case investigator's report, being a member of the case conference to decide on formal exclusion, advice on appropriate action when a practitioner is subject to criminal charges, to normally act as the contact point for appeals, contribute to course of action following occupational health assessment.

4.4.1.3 *Case investigator*

Aside from capacity and capability issues dealt with earlier, there are a variety of reasons why someone may be an inappropriate case investigator for example there may be a clear conflict of interest (not simply that the investigator knows or trained with the subject of the investigation)

The independence of investigators is also important. The term independence can be used as a sword and shield in equal measure and very often the subjectivity of the term can be extended to such an extent that it becomes virtually impossible to find or appoint an independent investigator. In a small jurisdiction such as Northern Ireland and an even smaller health community there are invariably instances whereupon everyone "knows" everyone else. This should not be deemed as the basis for recusal or refusal of investigators on the grounds of lack of independence and as such conflicts of interest must be real as opposed to perceived before alternate arrangements are sought.

The Labour Relations Agency guidance on conducting an employment investigation addresses this issue [page 7], *"an employment investigator may find his/her integrity being questioned from the outset and as such it is almost an occupational hazard which can be countered by the individual conducting the investigation in a professional, objective, timely manner and demonstrating consistent honesty and integrity throughout the process."* and suggests: "*A basic principle of investigation integrity is to ensure that the investigator has no connection with those subject to the investigation, thus using a manager from a different department to conduct the investigation is quite a normal approach. In smaller organisations such arrangements may not be possible, and an investigation may need to be conducted by a supervisor or manager who may have a connection but is required to be professional and objective in his/her handling of the investigation."*

4.4.1.4 *Case Managers*

MHPS set out that the medical director should be the case manager, and this seems incongruous and unnecessary if, as has been demonstrated by case statistics, the majority of cases relate to the behaviour of employed doctors and dentists. In light of a regionally applicable dignity at work policy, the review panel believed that the case manager role would be more appropriate for a member of HR staff given there is no obvious reason to limit the role to a medically qualified individual.

MHPS also refers to the case manager as the sole decision maker. Current good practice principles are that decision making should not rest with a sole individual and that membership of decision-making groups should comprise a minimum of three members and should be diverse.

4.4.2 Accompaniment & Representation

The right to be accompanied is derived from Article 12 of the Employment Relations (NI) Order 1999[12] and is applicable to workers and employees in Northern Ireland alike. The right was expanded upon in 2004 and applies if the individual is required or invited by his employer to attend a disciplinary or grievance hearing, and where the individual reasonably requests to be accompanied at the hearing.

The key issue is that the right to accompaniment at a statutory level is applicable to hearings, which is a grievance or a disciplinary, as opposed to investigatory meetings which are the pre-cursor to a hearing.

MHPS stipulates in paragraph 30 that "… *at <u>any</u> (our emphasis) stage of this process – or subsequent disciplinary action – the practitioner may be accompanied to an interview or hearing by a companion*…" and from here lists the various individuals who may act as an accompanying individual.

This clearly goes over and above the requirements of the law and as such is a gloss on the legal right both in terms of when the right can be invoked (i.e. – a forum other than a hearing) and who can act as the accompanying individual (i.e. - a union representative or work colleague).

In the public sector in Northern Ireland the lines between accompaniment and representation often become blurred due to ignorance of the law, the lack of precision in the collective agreement, uncertain custom and practice or indeed casual management of the process.

In many cases the paper may not reflect the practice and the provision in the final sentence in paragraph 30 regarding "…*the companion may be legally qualified but he or she will not be acting in a legal capacity*…" has been effectively dismissed as a construct by the judiciary in cases spanning back many years now and reflects a dated and discredited provision that exemplifies the accompaniment versus representation conundrum.

Based on the material presented to the panel on this right it is apparent that regarding MHPS its intention and operation differ and that it contributes to an adversarial

[12] https://www.legislation.gov.uk/nisi/1999/2790/contents/made

atmosphere and is often a staging post towards litigation rather than a mechanism for moral support. It is also felt that the inclusion of this at an early stage is counterproductive to the process and can cause escalation and unnecessary delays if not managed appropriately by case managers or case investigators.

The purpose of the investigation process is to elicit facts to inform the decision-making process. These facts need to come directly from those who are subject to or witnesses to the subject matter at hand. Thus, when the investigating officer puts a fact-finding question directly to the individual they should provide an answer. If the answer is provided by the representative (who was not present or witness to the events forming the line of questioning) then this demonstrates the problem of where accompaniment merges into de facto representation thereby undermining the basis of a proper investigation.

The simple legal demarcation between the two concepts turns on the ability to answer questions on the member's behalf despite the question being put directly to their member. The legislative purpose is to provide a mechanism of moral support as opposed to speaking on behalf of in an adversarial manner and as such sight of this seems to have become lost.

This may be due to the process of collective bargaining whereupon employee representative groups such as trade unions may seek to "gold-plate" a right in a well-intentioned provision, but which results in unintended operational consequences that often serves to stymie the process.

Based on the experience of the operation of the MHPS process, clarity regarding when someone can be accompanied and when they can be represented needs to be provided. Making provision for either in the investigation process has proved counterproductive especially given that the statutory right applies to hearings. New arrangements should ensure that these rights appropriately support the practitioner at the appropriate juncture in the process and that they are not counterproductive to advancing the case in a fair, timely and open manner.

4.4.3 Support

4.4.3.1 *Absence of mention of support for practitioner*

There is no stated recognition that being subject to these procedures (whether formal or informal) can prove stressful for the individuals concerned and others. There is no mention at any place of support for the practitioner in terms of their general well-being, other than when a health issue has been identified. Sources of internal and external support need to be communicated clearly. One suggestion worthy of development was a colleague providing informal support. It could be argued that the first source of support should be within the organisation itself, this could be a colleague identified by the practitioner themselves who is willing and able to provide moral support to the practitioner.

These may also support more positive engagement with the practitioner.

This failing can be met by the role of HR as outlined in the recommendation below.

4.4.3.2 *Support and advice available to employing organisations.*

The review panel heard that the support and involvement from the Practitioner Performance Advice Service had been crucial and employing organisations had been able to secure valuable advice which was welcomed in supporting the management and resolution of cases under MHPS. The review panel also noted that the PPA can also provide independent advice to the practitioner, although it was evident from stakeholder feedback that this is not widely known. The review panel heard that the GMC Employer Liaison Advisor is accessible to discuss referral thresholds and to advise the Responsible Officer on an as and when basis.

Conversely however, some stakeholders expressed a lack of rapid support for case managers and felt that better support is needed for the RO. These comments indicated to the review panel that the system would benefit from an increased awareness of the expert advice available to those managing concerns.

Recommendation 14 – The Case Manager should be the most appropriate person to manage the case and the role should not be limited to a clinician. The CM must be responsible for the drafting of Terms of Reference for investigations, receiving and reporting on the management of the case and preparing reports for consideration by the relevant decision-making group.

They must also provide the practitioner with an update on their case every 28 days (even when there is no update). They must play no part in decision making on the case.

Recommendation 15 – HR should nominate a named point of contact between the practitioner and the employer, and they should signpost the practitioner to health and wellbeing services (internal and external). The HR point of contact must make contact with the practitioner every 28 days for a health and well-being check.

Recommendation 16 – HSC Employing organisations should acquaint themselves with where they can seek either advice or services that might help with an assessment of the presenting concern and this should be extended to where the practitioner can be signposted to.

Recommendation 17 – The relevant policies on managing the performance concern must provide clarity on the parameters and circumstances that allow an employee to be accompanied and the circumstances as to when they can be represented as making provision for either right in the investigation process has proved counterproductive especially given that the statutory right applies to hearings only. Arrangements should ensure that these rights appropriately support the practitioner at the appropriate juncture in the process and that they are not counterproductive to advancing the case in a fair, timely and open manner.

Recommendation 18 – All decision making should be carried out by a panel; this is for both the screening stage and other stages of decision-making. It does not need to be the same panel for each stage. Panels should be drawn from individuals who have had no prior involvement in the matters to be considered. Good practice suggests a panel should consist of no less than a three-members.

Recommendation 19 – The RO must be kept informed of issues that arise about a doctor's fitness to practise.

4.5 Finding 4 – Oversight, Governance & Accountability

Governance is "the system by which an organisation directs and controls its functions and relates to its stakeholders". In other words, the way in which organisations:

- manage their business.
- determine strategy & objectives.
- go about achieving these objectives.

4.5.1 Governance

The Department has produced a Framework Document (2014) to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009[13]. The Framework Document describes the roles and functions of the various health and social care (HSC) bodies and the systems that govern their relationships with each other and the Department.

The Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the Reform Act") provides the legislative framework within which the health and social care structures operate. It sets out the high-level functions of the various HSC bodies. It also provides the parameters within which these bodies must operate and describes the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003).

[13] https://www.legislation.gov.uk/nia/2009/1/contents

The Framework Document describes the various lines of accountability and how they are exercised at different levels within the HSC system. The key performance and assurance roles and responsibilities are encompassed in the domains of:

- Corporate Governance
- Quality
- Service delivery.
- Service improvement.

Some key principles underpin the overall approach to holding the HSC system to account:

Whilst the Department retains overall accountability for HSC performance, each HSC body is locally accountable for its organisational performance across the four domains and for ensuring that appropriate assurance arrangements are in place. This obligation rests wholly with the body's board of directors. It is the responsibility of boards to have systems and procedures in place to identify and manage the performance of their staff and to manage emerging issues at a local level in the first instance. As part of its continuous improvement cycle, Boards would be expected to be able to demonstrate learning from their activity and in part this would be derived from considering their own metrics and by comparing their metrics with a similar size organisation to identify variance and to derive learning accordingly.

The review panel agreed that the availability of timely and accurate metrics is a prerequisite to good governance and organisations must be able to collect and record data to create visibility in this area of work. As previously noted, recording of data in support of these ends is inconsistent at present.

MHPS has a focus on responsibility in terms of roles, but this is not matched or linked with accountability and is hindered by issues that have hampered MHPS since its inception in terms of poor role clarity within those responsible roles.

Governance, since the development on MHPS in 2005 has gone through radical change and has seen significant step improvements within the HSC in terms of oversight methodologies in every arena from risk register compilation through to the handling of serious adverse incidents (SAI's) and many systems in between.

This feeds into the issues surrounding the lack of capacity and capability within HSC employing organisations and the blurring of lines of accountability to address issues such as the management of the process and poor-quality investigations.

MHPS implies there is a detailed and thorough governance and oversight structure because there is an explicit requirement to escalate to the highest level in the organisation. In reality however, there is no day-to-day governance and oversight of how a case is managed through the system and brought to a timely and appropriate conclusion with no explicit accountability of actions taken/not taken by the Board or the Department.

The panel is cognisant that MHPS is a 2005 document that lacks the necessary governance rigour of a 2024 fit for purpose process and as such falls short of the current requisite standards of governance.

Performance, conformance and accountability of the processes should be supported by the statistics – Policies, such as Regionally applicable dignity at work need to be measured using appropriate governance metrics to ensure for example that completion timeframes and investigation protocols are consistent.

4.5.2 Non-Executive Director

MHPS whilst genuine in original intention does not reflect modern governance practices in the public sector in Northern Ireland. Indeed, the lack of governance architecture around MHPS is perhaps one of its great frailties as demonstrated by a clear lack of accountability at all levels of involvement throughout the operation of MHPS.

MHPS cites the role of the Non-Executive Director (NED) as being, inter alia, "… *to oversee, maintain momentum, consider representations on the investigation or exclusion...*" Stakeholders and the panel alike see this role as nebulous at best given that NEDs should not have a functional role in such an operational process for a variety of reasons ranging from disproportionate/inappropriate level of engagement through to potential for process contamination.

The code of conduct for Non-Executive Board Members & code of accountability for board members of health & social care bodies (2022)[14] states:

[Para 12] *non-executive board members are appointed by the Minister for Health, to bring an independent judgement to bear on issues of strategy, performance, key appointments, and accountability, through the Department, to the Minister and to the local community.*

In addition, they undertake specific functions agreed by the board including an oversight of staff, relations with the general public and the media, participation in professional conduct and competency enquiries, staff disciplinary appeals and procurement of information management and technology. Their exercise of such functions should be in a non-executive capacity.

For someone at directorial level to have operational involvement regarding de facto appeals over process and procedure as well as an oversight role and seeming ability to "move the process along" seems entirely misplaced and at odds with contemporary good governance and having appropriate role clarity and necessary firewalls.

This role seems confused with that of process manager (as opposed to an individual case manager) and as such this speaks to the lack of clarity and disconnect between operational and managerial levels of process responsibility.

The panel was of the view that this needs to be addressed by more comprehensive and modern governance assurance mechanisms which are fit for modern purpose in the HSC or any other part of the Northern Ireland public sector.

Effective data collection, management oversight and routine reporting mechanisms will fill this gap and support organisation's boards to fulfil their responsibilities in this area and their accountability to the Department.

The panel heard that NEDS were not trained sufficiently to provide adequate oversight of complex investigations or equipped to robustly challenge and, similarly to case investigators and case managers, the infrequency of cases rendered them unfamiliar with what good looked like. It was noted that NEDs involved in the USI were unaware of how they could interact with management to provide either challenge or support for

[14] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-code-conduct-accountability-hsc-bodies.pdf

the process. Others believed that the role of the NED was underutilised and that more could be achieved through an extension of NEDs involved in the oversight and assurance process.

4.5.3 Levels of Accountability

Allied to the shortfalls in governance architecture the panel recognised that MHPS has in the main operated in isolation since 2005 and without the recognised governance methodologies to support its continuation. The net effect of this is that the review panel considers that it has lost its prominence and now lacks accountability both in terms of functionality and hierarchy.

This issue pervades through every level of accountability and is accompanied by other issues such as flaws in day-to-day management and appraisal processes whereupon greater integration with other regulatory and local policy development would have enabled issues such as poor behaviour or conduct to have been identified and nipped in the bud. Such timely intervention could have led to early modification of behaviour rather than a formal process.

The panel is cognisant that some may perceive the differential between functional responsibility and accountability as splitting hairs but the outcomes of many MHPS processes analysed by the panel show recurring themes especially around the process being an amalgam of functions not underpinned by accountability.

To this extent the panel wish to ensure that there is purposeful distinction between – role clarity, functional responsibility and assigned accountability provided for in any process which may supplant MHPS.

During the review the panel was reminded that employing organisations are not required to provide routine reporting to an external body of the numbers or time taken to manage a concern let alone the outcome and likewise there is no accountability when delays occur. Feedback provided during the Urology Services Inquiry confirmed that witnesses considered that there should be ‘external supervision’ associated with the MHPS processes.

4.5.4 Department of Health oversight

The review panel found that there is a lack of accountability at different junctures not only within the HSC employing organisations but also between the HSC employing organisations and the Department.

The fact that the role of the Department in the operation of MHPS only really becomes apparent when they are required, under paragraph 30 regarding the exclusions process, to be kept informed of exclusion extensions speaks of this gap and the lack of governance architecture and detachment that exists between the two.

Based on the feedback the panel received from the individual HSC employing organisations it is apparent that there are significant divergences in practices between them in and around MHPS and this impacts on approach and outcome accordingly.

This information was not held centrally by the Department and as a result the Department was neither able to "take the temperature" of MHPS nor make provision for consistency of approach across the HSC employing organisations.

The panel is conscious that this issue may not be unique to MHPS and as such there may be an argument that this is an employment matter for each of the HSC employing organisations to deal with accordingly. However, when looked at through the lens of a Serious Adverse Incident (SAI) or retrospectively via a public inquiry where MHPS played a significant part, there is a clear need for a departmental level oversight mechanism to exist and be interrogated accordingly.

Recommendation 20 – HSC employing organisations should be able to demonstrate effective internal governance protocols which are consistent with NI HSC principles with oversight and clear lines of accountability. These should include standardised provisions regarding role clarity and be predicated on contemporary governance protocols in use in other parts of the public sector in Northern Ireland.

Recommendation 21 – Regional templates should be developed and uniformly adopted to record a data set of all performance concerns raised and the management and disposal of it.

Recommendation 22 – Reports should be provided to the Board of the employing/contracting organisation on a quarterly basis detailing metrics and themes.

Recommendation 23 – HSC employing organisations should be required to submit an annual report to the Department, which should include, activity figures, outcomes and lessons learnt.

Recommendation 24 – HSC employing organisations should review their record retention policies to ensure that they are retaining information such as complaints and issues relating to a doctors/dentist's practise for the duration of their medical/dental working career and ensure this complies with GDPR provisions.

5.0 Conclusion

The review process engaged with a broad range of organisations who have used the MHPS framework at an operational or management level on a regular basis. It engaged with practitioners who had been the subject of an MHPS process and experienced firsthand how the framework had been applied in the management of their case. It further engaged with organisations that provide support and advocacy for practitioners involved in such processes. These stakeholders were unanimous in their view that the MHPS process was outdated and not fit for purpose.

In stepping back from the Framework itself, the panel found it challenging to disentangle how much of the issues raised are a product of what is written, including the rationale for treating doctors and dentists separate to any other healthcare employee, or the extent to which the framework is applied within the context of the organisational culture. Indeed, the review panel questioned how much is a reflection that MHPS, simply put, no longer fits with the current landscape of governance and regulatory reform.

Irrespective of the causation and along with the opinions offered by other parallel review panels and inquiries the MHPS review panel agreed with stakeholders that MHPS is no longer fit for purpose and that new arrangements (in some form) are necessary.

The review panel was mindful that the Terms of Reference 14 and 15 required it to '*produce a draft revised version of the MHPS framework*' and '*produce guidance to support operation of the framework across HSC.*' During the course of its work, the panel agreed that the fulfilment of these two Terms of Reference would be in direct conflict with the recommendations that it had drawn up and that are set out in the preceding paragraphs. If these recommendations are accepted and implemented, these in and of their own would provide a solid foundation for HSC to develop capacity, capability, and confidence in managing concerns consistently in a fair, open and proportionate manner and establish appropriate reporting to support robust governance and accountability.

5.1 Benefits of Acceptance and Implementation of Recommendations

In the years that MHPS has been in operation, experience, from whatever quarter it is drawn, has demonstrated that there exist some fundamental shortcomings in the procedure which were exposed by their application to various sets of facts. Despite the associated negativity it is vital to draw upon the experience and lessons learned regarding how a reformed approach can help in terms of – ease of use, clarity over interpretation, interaction with other policies and other benefits such as those listed below:

- Greater consistency in the application
- Equity
- Timeliness
- Improved capacity and capability
- Positive impact on well-being
- More open, just, and transparent process
- Improved trust within the process

5.2 Further considerations

If the recommendations within this report are accepted the Steering Group may also wish to consider the following proposals:

5.2.1 Implementation

MHPS was issued under a Departmental Direction in November 2005. The Direction, required employing organisations to "*notify the Department of the action they have taken to comply with the framework by 31 January 2006*."

At the time of issue there was no statement of the specific actions required and no requirement from employing authorities to make any subsequent declaration of actions taken, nor any follow up seeking such declarations.

This lack of precision in process may have contributed to subsequent issues with the application of MHPS and as such should be avoided in the development and implementation of future procedures for the management of concerns regarding doctors' and dentists' performance.

5.2.2 Immediate action

In the short term, the Department should issue uniform guidance to employing authorities on its expectation on the application of MHPS. The guidance should be a clear statement of principles covering.

- As detailed in recommendation five, the current processes must include an initial consideration of a concern that affects an individual's performance whether this arises from a potential conduct, capability or health issueand should involve a screening process. This screening should be part of day-to-day management and should help inform what if any action is required, including whether there is a conduct, capability, or health issue. This should be implemented immediately.
- The clear intention to deal with concerns regarding medical and dental practitioners' performance through routine day to day management in the first instance, in the expectation that this will inform an agreed course of action in the majority of cases.
- Line managers should have access to support from within the organisation to meet this expectation.
- These cases should be adequately documented (stating the specifics of the concern, its source(s), information accessed to inform next steps, a conclusion and options on next steps) even when the decision is to take no further action.

In parallel with investigating the concern and from the outset, consideration must be given to the potential impact on patient safety and a separate report should be prepared setting out the potential safety concern(s), how best these can be mitigated, and the practitioner's view, and if the mitigations involve restrictions of their practice.

This approach is broadly in line with the Assessment stage set out in the HSC wide Regional Disciplinary Policy and Procedure. Indeed, sections 1 -7, could be considered generic and applicable to any concern. This should allow the fulfilment of the clear statement in paragraph 5 of the introduction to MHPS "Local conduct procedures will apply to all concerns about the conduct of a doctor or dentist."

In addition:

- A further necessary principle therefore is that local conduct procedures will apply to all concerns about the conduct of a doctor or dentist from the outset.
- All HSC employing authorities should adopt consistent principles on how to manage concerns as already used by two employing organisations pending the introduction of revised arrangements.

Finally:

- A process and guidance document should be developed for how mid-process cases are dealt with during the transition period.

5.2.3 Employing authorities

Employing authorities must:

- Identify individuals from requisite backgrounds to support line managers in informal/day-to-day management/screening of reported performance concerns.
- Identify/appoint individuals from requisite backgrounds to develop appropriate expertise in handling cases both in support of local line managers and in contributing to a regional resource which conducts performance/employment investigations. Such individuals would require dedicated time set aside for this activity, regular and repeated training in good practice of investigations and working knowledge of application of related procedures.
- All HSC employing organisations should ensure that the current Regional Disciplinary Policy and Procedure is adopted and implemented.
- Begin the development of HSC wide regional capability and health procedures that are applicable to all HSC staff.

6.0 Recommendations

The following recommendations are made to support the delivery of new procedures across the HSC for the handling of concerns for all HSC employed staff to include doctors and dentists who are currently subject to MHPS. Where concerns are referred to in this report, these are concerns that relate to an individual's performance (whether these arose within the workplace, or occurred outside the workplace that might affect their performance or standing within the workplace) which might arise from their conduct, capability, or health (or a combination of these)

If recommendations one to four below are accepted and implemented these would replace the existing MHPS framework.

6.1 The purpose of MHPS

Recommendation 1

Medical and Dental practitioners should be subject to the same HR policies that address performance concerns applicable to other HSC employees.

Recommendation 2

The Regional Disciplinary Policy and Procedure should be amended to include Medical and Dental staff from the initial raising of a concern. Its universal adoption by all HSC employing organisations should be mandated by the Department.

Recommendation 3

The Regional Disciplinary Policy and Procedure should be used as a template to develop a separate regional document to address capability issues which applies to all HSC staff including medical and dental staff and its universal adoption by all HSC employing organisations should be mandated by the Department.

Recommendation 4

The Regional Disciplinary Policy and Procedure should be used as a template to develop a separate regional document to address health related performance issues which applies to all HSC staff including medical and dental staff and its universal adoption by all HSC employing organisations should be mandated by the Department.

6.2 The MHPS Process

Recommendation 5

Current and future replacement processes must include an initial consideration of a concern that affects an individual's performance whether this arises from a potential conduct, capability or health issue and should involve a screening process. This screening should be part of day-to-day management and should help inform what if any action is required, including whether there is a conduct, capability or health issue or a combination of these.

Recommendation 6

If at the conclusion of the screening process, a clear course of action has not been determined from the information gathered, Terms of Reference should be drafted for a subsequent investigation. A case manager and case investigator should be appointed at this stage.

The Terms of Reference for an investigation must be shared with the practitioner before the investigation commences. Any information shared with the investigator must also be shared with the practitioner. The investigation report must address and answer the Terms of Reference and be evidence based. The investigation report prepared should set out the context and situation and the findings considered within a band of reasonable responses given these factors. The practitioner must be given a copy of the report to enable them to comment on any matters of factual accuracy before the report is finalised.

Recommendation 7

Current and future replacement processes must be fair, open, and transparent with the practitioner and the practitioner should be made aware of the initial concern and information available at the outcome of the initial screening process and be given the opportunity to respond.

Recommendation 8

Employing organisations should identify individuals to contribute to a dedicated pool to support processes (predominately investigations) within individual organisations.

Case managers and case investigators must have dedicated time identified and receive on-going training aimed at maintaining a range of up-to-date knowledge, skills and experience.

Recommendation 9

The justification for any referral to another party must be recorded and should only happen when there is clear evidence that it is necessary to do so to protect the safety of patients, staff or public and or the efficiency of HSC services and the practitioner should be informed of this.

Recommendation 10

Information must be shared with the doctor's RO and the RO must be kept informed of investigations and/or questions raised regarding a doctor's fitness to practice. Where there are serious concerns raised about a doctor's practise and it is known that the doctor has additional scope of work outside of the primary employing authority, there should be a discussion with the other employing/contracting organisation followed by appropriate information sharing.

Recommendation 11

If the assessment of the concern indicates a risk to the practitioner and or service and an exclusion or restriction is put in place these arrangements must be reviewed at least every 28 days and the rationale for either maintaining the exclusion/restriction or revoking/amending must be recorded.

Recommendation 12

Any relevant timescales specified in the relevant policy must be reasonable, promote timeliness and consider foreseeable delays. Any delays should be recorded together with the justification for it. The practitioner must be informed at the earliest opportunity.

Recommendation 13

Confidentiality should not impinge on patient safety aspects or the utilisation of information, but good information governance should be adhered to, and awareness should be raised on ways of achieving this. The personal data guardian should be consulted as appropriate regarding qualified confidentiality.

6.3 Roles & Responsibilities and Rights of those involved in the MHPS process.

Recommendation 14

The Case Manager should be the most appropriate person to manage the case and the role should not be limited to a clinician. The CM must be responsible for the drafting of Terms of Reference for investigations, receiving and reporting on the management of the case and preparing reports for consideration by the relevant decision-making group. They must also provide the practitioner with an update on their case every 28 days (even when there is no update). They must play no part in decision making on the case.

Recommendation 15

HR should nominate a named point of contact between the practitioner and the employer, and they should signpost the practitioner to health and wellbeing services (internal and external). The HR point of contact must make contact with the practitioner every 28 days for a health and well-being check.

Recommendation 16

HSC Employing organisations should acquaint themselves with where they can seek either advice or services that might help with an assessment of the presenting concern and this should be extended to where the practitioner can be signposted to.

Recommendation 17

The relevant policies on managing the performance concern must provide clarity on the parameters and circumstances that allow an employee to be accompanied and the circumstances as to when they can be represented as making provision for either right in the investigation process has proved counterproductive especially given that the statutory right applies to hearings only. Arrangements should ensure that these rights appropriately support the practitioner at the appropriate juncture in the process and that they are not counterproductive to advancing the case in a fair, timely and open manner.

Recommendation 18

All decision making should be carried out by a panel, this is for both the screening stage and other stages of decision-making. It does not need to be the same panel for each stage. Panels should be drawn from individuals who have had no prior involvement in the matters to be considered. Good practice suggests a panel should consist of no less than three-members.

Recommendation 19

The RO must be kept informed of issues that arise about a doctor's fitness to practise.

6.4 Oversight, Governance & Accountability of MHPS

Recommendation 20

HSC employing organisations should be able to demonstrate effective internal governance protocols which are consistent with NI HSC principles with oversight and clear lines of accountability. These should include standardised provisions regarding role clarity and be predicated on contemporary governance protocols in use in other parts of the public sector in Northern Ireland.

Recommendation 21

Regional templates should be developed and uniformly adopted to record a data set of all performance concerns raised and the management and disposal of it.

Recommendation 22

Reports should be provided to the Board of the employing/contracting organisation on a quarterly basis detailing metrics and themes.

Recommendation 23

HSC employing organisations should be required to submit an annual report to the Department, which should include, activity figures, outcomes and lessons learnt.

Recommendation 24

HSC employing organisations should review their record retention policies to ensure that they are retaining information such as complaints and issues relating to a doctors/dentist's practise for the duration of their medical/dental working career and ensure this complies with GDPR provisions.

Appendices

Appendix A

Independent Review Panel Pen Profiles

Dr Paddy Woods – Review Panel Chair

Dr Paddy Woods is a former Deputy Chief Medical Officer for the Department of Health. He joined the Department in 1992, having previously trained in general practice. Initially, he held the remit on general medical practice and maternal and child health. In 1998, he took on the role as the Department's Adviser in Medical Staffing and Development. In May 2010, He became Deputy Chief Medical Officer, subsuming his former role and taking overall responsibility for areas of safety and quality and medical advice more generally until his retirement.

Manda Copage

Manda provides expertise and independence to healthcare organisations who are managing performance concerns, grievances or appeals relating to healthcare professionals. She is a skilled and experienced case investigator; case reviewer and case manager having undertaken extensive work in this area at an operational level, a national policy development level and national advisory level since 2006. She has practical experience of working in NHS primary, community and secondary care, and working with the independent sector, including Crown Dependency organisations, defence medical services and HMP healthcare.

She has chaired and been a member of various professional performance decision making groups and since 2013 has trained thousands of staff (line managers, decision makers and chairs of panels) on all aspects of managing concerns that arise in the healthcare setting. She brings with her a wealth of knowledge and insight into this field having worked for more than five years as a senior adviser for the Practitioner Performance Advice Service (formerly the National Clinical Assessment Service) providing specialist advice across the UK and Crown Dependencies on the Performers List Regulations, Responsible Officer Regulations and Maintaining High Professional Standards. She continues to work with the Advice Service as an associate.

In addition to her expertise in the management of healthcare professionals, she now chairs employment disciplinary, grievance and appeal panels and sits on school governor exclusion panels.

She is also National Head of Professional Standards and Performers Lists for NHS England

Mark McAllister

Mark is currently the Director of Employment Relations Services for the Labour Relations agency.

Mark has been with the Labour Relations Agency for 20 years working in all frontline services as well as the corporate services side of the organisation. Mark was appointed Director of Employment Relations Services in May 2019.

Prior to joining the Agency Mark was a legal academic and a regional trade union negotiator in the further and higher education sector from 1995 – 2000. He is an experienced mediator, author and contributor to employment law publications and a regular speaker on the employment law circuit in Northern Ireland.

Mark has worked in a variety of voluntary capacities such as community mediation and is a former Chair of Community Restorative Justice Ireland. In addition, Mark has held the post of Northern Ireland Convenor of the Chartered Institute of Arbitrators and the Chair of the Governance Institute (NI) Branch.

Mark has a variety of formal academic qualifications including a master's degree in law and public administration. He is a member of CiARB and a Fellow of the Governance Institute (ICSA) as well as holding memberships in the Employment Lawyers Group (NI) and the Industrial Law Society.

Appendix B

Glossary of Terms

ALB	Arm's Length Body
CE	Chief Executive
CI	Case Investigator
CM	Case Manager
DB	Designated Bodies
DoH	Department of Health
GMC	General Medical Council
HPSS	Health and Personal Social Services (now known as HSC)
HR	Human Resources
HSC	Health and Social Care
INI	Independent Neurology Inquiry
MDO	Medical Defence Organisation
MHPS	Maintaining High Professional Standards
NCAS	National Clinical Assessment Service
NED	Non-executive Director
NHS	National Health Service
NIMDTA	Northern Ireland Medical and Dental Training Agency
PPA	Practitioner Performance Advice
PSNI	Police Service of Northern Ireland
RO	Responsible Officer
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incidents
SAR	Subject Access Request
USI	Urology Services Inquiry

Appendix C

Stakeholder List

Stakeholder Group	Organisations within Group	Representatives
HSC Organisations	Belfast Health and Social Care Trust Business Support Organisation Departmental Legal Services Northern Health and Social Care Trust Northern Ireland Ambulance Service Northern Ireland Blood Transfusion Service Northern Ireland Medical Dental Training Agency Public Health Agency Southern Health and Social Care Trust Strategic Planning & Performance Group The Regulation & Quality Improvement Authority Southeastern Health and Social Care Trust Western Health and Social Care Trust	Board Members HR Directors HR Management Medical Directors Medical Management Postgraduate Dean Responsible Officers Head of Legal Services Controlled Drug Accountable Officers
Indemnity Organisations	Medical Defence Union Medical Protection Society	
Medical and Dental professionals who have been subject to MHPS investigations	All medical and dental professionals who had been subject to MHPS since 2016	32 individuals invited and 15 engaged
NHS Organisation	Mersey Care	Executive Director of Workforce
PPA		
Regulatory Organisations	General Dental Council General Medical Council	
Royal Colleges	Royal College of Anaesthetists Royal College of Emergency Medicine Royal College of Obstetricians and Gynaecologists Royal College of Paediatrics and Child Health	

	Royal College of Pathologists Royal College of Physicians Royal College of Physicians and Surgeons of Glasgow Royal College of Physicians Ireland Royal College of Physicians of Edinburgh Royal College of Psychiatrists Royal College of Radiologists Royal College of Surgeons Ireland Royal College of Surgeons of Edinburgh Royal College of Surgeons of England The Royal College of Ophthalmologists	
Trade Unions	British Dental Association British Medical Association Hospital Consultants and Specialists Association	Union officials

Appendix D

Review of MHPS

Initial Stakeholder Engagement Questionnaire

Employing Organisations

Section 1 Organisational Response – Data Collection		
1	Your Name	
2	Your organisation	
3	Your role in the organisation	
4	The Review Panel intend to conduct face to face engagement with stakeholders in the autumn. The engagement, while focusing on the operation of MHPS, will likely also cover the management of medical and dental staff and human resource management issues more generally. Please advise who within your organisation would be best placed to meet with the panel for this in-depth discussion. This can be more than one person. Please also advise of contact details and roles of the nominees that you propose.	
5	It is hoped to carry out the face-to-face engagement during week commencing 25th September. Please indicate if any of the dates that week would not be suitable for your organisation for this engagement	

Section 2 - Experience of the operation of the INFORMAL approach to Maintaining High Professional Standards							
			2016	2017	2018	2019	2022
1	How many investigations adopting the informal approach were commenced in each of the following CALENDAR years						
2	How many were:	Medical					
		Dental					
3	Breakdown of investigations by Grade	Training Grade					
		SAS Doctor/Dentist					
		Consultant or equivalent					
		Other (please detail)					
4	How many investigations were completed within the following time periods;	4 weeks					
		1-3 months					
		3-6 months					
		6–12 months					
		Remain uncompleted					
5	Of the informal investigations how, many fell into the following categories.	Behavioural/Misconduct only					
		Clinical capability only					
		Health only					
		Behavioural/misconduct & Clinical capability					
		Behavioural/misconduct & Health					
		Clinical capability & Health					
		Behavioural/misconduct & Health & Conduct					
6	Of the informal investigations that were completed, how many resulted in. (where more than one outcome resulted, please count each separate outcome)	No further action					
		Referral to occupational health service no further action					
		Referral to occupational health service and further referral					
		Referral to a conduct panel					
		Referral to a clinical performance panel					

		Referral to GMC or GDC					
7	In your experience of informal investigations under MHPS, what factors cause delays in completing the process?						
8	How might such delays be avoided or mitigated?						

Section 3 - Experience of the operation of the FORMAL proceedings under Maintaining High Professional Standards							
			2016	2017	2018	2019	2022
1	How many formal investigations were commenced in each of the following CALENDAR years.						
2	How many were:	Medical					
		Dental					
3	Breakdown of investigations by Grade	Training Grade					
		SAS Doctor/Dentist					
		Consultant or equivalent					
		Other (please detail)					
4	How many investigations were completed within the following time periods;	4 weeks					
		1-3 months					
		3-6 months					
		6–12 months					
		Remain uncompleted					
5	Of the formal investigations what were the concerns raised	Behavioural/Misconduct only					
		Clinical capability only					
		Health only					
		Behavioural/misconduct & Clinical capability					
		Behavioural/misconduct & Health					
		Clinical capability & Health					
		Behavioural/misconduct & Health & Conduct					
6	Of the formal investigations that were completed, how many resulted in. (where more than one outcome resulted, please count each separate outcome)	No further action					
		Decision by a conduct panel					
		Consideration though health procedures					
		Decision by a clinical performance panel					
		Referral to GMC or GDC					
7	In your experience of formal procedures under MHPS, what factors cause delays in completing the process?						

8	How might such delays be avoided or mitigated?

Section 4 - Experience of exclusion under Maintaining High Professional Standards							
			2016	2017	2018	2019	2022
1	How many exclusions were commenced in each of the following CALENDAR years.						
2	How many were:	Medical					
		Dental					
3	Breakdown of exclusions by Grade	Training Grade					
		SAS Doctor/Dentist					
		Consultant or equivalent					
		Other (please detail)					
4	How many exclusions were discontinued within the following time periods	4 weeks					
		1-3 months					
		3-6 months					
		6–12 months					
		Remain in place					
5	In your experience of exclusions under MHPS, what factors lead to lengthy/indeterminant exclusions?						
6	How might lengthy/indeterminant exclusions be avoided or mitigated?						

Section 5 - Experience of the involvement of NHS Resolution's Practitioner Performance Advice (PPA) under Maintaining High Professional Standards							
			2016	2017	2018	2019	2022
1	In how many cases (whether at informal or formal stage) did you seek advice from the PPA in each of the following CALENDAR years						
2	How many were:	Medical					
		Dental					
3	Breakdown of exclusions by Grade	Training Grade					
		SAS Doctor/Dentist					
		Consultant or equivalent					
		Other (please detail)					
4	What was the nature of advice	Purely advisory					
		Facilitated mediation					
		Clinical Performance assessment					
		Behavioural Assessment					
		Action Plan/Return to Work					
5	In how many cases was the intervention from PPA helpful in bringing the case to a prompt and satisfactory conclusion?						
6	What were the issues where PPAs involvement did not facilitate a prompt and satisfactory conclusion?						
7	How might such issues be avoided or mitigated?						

Appendix E

MHPS Review

Overview

Thank you for your response and for expressing an interest in engaging with the Review Panel which, as you are aware, has been established to carry out a review into Maintaining High Professional Standards (MHPS).

The Review Panel consider the perspective of those Medical and Dental professionals who themselves have been subject to the MHPS process as important, given the specific insights and experiences you will have arising from your involvement in the process.

We have devised this short questionnaire to aid in the gathering of your experiences. Please note that Section 1 of the questionnaire will only be viewed by the Project Team and is for data collection purposes only. The review panel will not have access to this information.

The remaining Sections 2 – 8 provide you with the opportunity to relay your experiences of and opinions on the overall process and framework. These responses will be anonymised and will be viewed only by the Project Team and Review Panel. All responses will be treated with the utmost confidentiality.

Please note once again that the Review Panel is not in a position to consider the final outcome of your case, nor the actions of individuals involved in your case. It is an opportunity for you to provide the review panel with your experience of the overall process and the MHPS Framework.

Following the analysis of the responses the Review Panel may consider seeking further information from you and if this is the case, the Project Team will contact you via the email address provided to make the appropriate arrangements.

We will accept responses up until 5pm on 6th December 2023. If you require any further information regarding this exercise, the Project Team can be contacted via email on the following address: **mhpsreview@health-ni.gov.uk**. This email address should also be used if you require a copy of this questionnaire document in an alternative format, or language other than English, as these can be made available on request.

Thank you again for agreeing to provide input to this important review and we look forward to hearing from you and receiving your valuable insight into the current MHPS process.

Section 1 Your information

1 What is your name?
Name *(Required)*

2 What is your email address?
Email *(Required)*

3 What was organisation at time you were subject to the MHPS process
Organisation *(Required)*

4 What is your grade?
(Required) (please select the most appropriate answer by deleting the ones that do not apply)

- Training Grade
- SAS Doctor/Dentist
- Consultant or equivalent
- Other (please detail below)
-

5 Are you still employed by the organisation where you were the subjectof the investigation you refer to below?
(Required) (please select the most appropriate answer by deleting the ones that do not apply)
Please select only one item

- Yes (please go to Q6)
- No (please go to Q7)

6 What is your current employment status within the organisation where the MHPS process was invoked?
Please select only one item (please select the most appropriate answer by deleting the ones that do not apply)

- Employed and working.
- Employed but currently off work.
- Employed and working in a different role following MHPS investigation.
- Other (please detail)

7Your current working status
Please select only one item (please select the most appropriate answer by deleting the ones that do not apply)

- Resigned and working clinically elsewhere within HSC.
- Resigned and working clinically elsewhere within independent sector.
- Retired and not working clinically.
- Retired and working clinically elsewhere within independent sector.

- Other (please detail)

Section 2 – The MHPS Process

8 Have you been subject to more than one MHPS investigation?
(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.

- Yes (please go to Q9)
- No (please go to Q10)

9 If you have answered yes to Q8, please provide the calendar year of each MHPS investigation.
For the remainder of the form please use your most recent experience.

10 In what year did you become aware you were the subject of the MHPS process? *(Required)*

11 How soon after the concerns were raised, were you made aware you were subject to an MHPS investigation? *(Required)*

12 How were you made aware?
(Required) (please select the most appropriate answer by deleting the ones that do not apply)
Please select only one item

- Verbal communication
- Verbal communication followed by written communication.
- Written communication only

13 Which process did you go through? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Informal only
- Formal only
- Informal then formal
-

14 Which category did your investigation fall into? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Behavioural/Misconduct only
- Clinical capability only
- Health only
- Behavioural/misconduct & Clinical capability
- Behavioural/misconduct & Health
- Clinical capability & Health
- Behavioural/misconduct & Health & Conduct

15 How long was the full MHPS process from start to finish? *(Required)*

(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.

- 4 weeks
- 1-3 months
- 3-6 months
- 6–12 months
- 12 months + (please state length below)
- Remains uncompleted

16 Did the process come to a conclusion? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes
- No

17 If the process was not able to be concluded, were you informed why? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes
- No

Section 3 – Temporary Restrictions

18 Were you subject to temporary restrictions on your practice? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes
- No (if not please move to Q21)

19 Were you advised as to the reason for the temporary restrictions *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item?*

- Yes
- No

20 What temporary restriction was placed on your practice? *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Restriction of some clinical duties
- Restriction of all clinical duties
- Required to provide undertakings e.g. regarding practice elsewhere.
- Temporary exclusion from the workplace
- Other (please specify below)

Section 4 – Absence during the MHPS process

21 Were you absent from work during the MHPS process (other than forprearranged annual leave or CPD) *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item?*

- Yes (please go to Q 22)
- No (please go to Q23)

22 If you were absent from work during the MHPS process, please indicate the reason why (you can choose more than one option) *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Exclusion
- Sick absence
- Other reason (please specify below)

23 Were you subject to an exclusion either an initial immediate exclusion or a formal exclusion? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes (please go to Q24)
- No (please go to Q31)

24 Were you advised as to the reason for the exclusion? *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes
- No

25 Were you subject to more than one exclusion during the same investigation? *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes
- No

26 The framework states that during the informal stage an 'initial' immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. How long did your exclusion last for? *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- 4 weeks
- 1-3 months
- 3-6 months
- 6–12 months
- 12 months + (please state length below)
- Remains in place

27 During this period of exclusion, the framework states that the practitioner should be given the opportunity to state their case and propose alternatives to exclusion. Where you provided this opportunity to propose alternatives to exclusion? *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes (please go to Q28)

- No (please go to Q30)

28 What alternatives to exclusion did you ask for? *(please select the most appropriate answer by deleting the ones that do not apply) Please select all that apply.*
- further training
- referral to occupational health
- referral to the NCAS with voluntary restriction
- Other (please specify below)

29 If you answered yes to Q27, what alternatives that you asked for atQ28 did the employer agree too? *(please select the most appropriate answer by deleting the ones that do not apply) Please select all that apply.*
- further training
- referral to occupational health
- referral to the NCAS with voluntary restriction
- Other (please specify below)

30 If you were formally excluded how long did this exclusion last? The framework states normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*
- 4 weeks
- 1-3 months
- 3-6 months
- 6–12 months
- 12 months + (please state length below)
- Remains in place
- Not formally excluded.

Section 5 – Support during the process

31 Did your employer offer you support through the process? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*
- Yes (go to question 32)
- No (go to question 33)

32 If you were offered support through the process by your employerwhat form did this take? (150-word limit)

33 What improvements could be made to the support that was offered by your employer? (150-word limit) *(Required)*

Section 6 – Employment after MHPS Process

34 Following the conclusion of the MHPS process did you continue orreturn to

work for the same organisation? *(Required) (please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes (please go to Q35)
- No (please go to Q36)

35 If you continued to work for the same organisation following the conclusion of the MHPS process, did you stay for more than 3 months? *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes
- No

36 If you left the organisation, was it due to the MHPS process? *(please select the most appropriate answer by deleting the ones that do not apply) Please select only one item.*

- Yes
- No

Section 7 – Overall process

37 MHPS is predicated on the need for specific arrangements to address performance concerns in medical and dental practitioners employed by trusts/ALBs. Do you think there is a need for a process specific for medical/dental practitioners or is it possible/desirable/feasible for the process to be subsumed into one for HSC staff as a whole? Please comment (150-word limit) *(Required)*

38 Our feedback to date suggests blurring between the informal and formal elements of the process with rapid (and possibly unwarranted) escalation into formality. Was this your experience and do you have any thoughts on this? Please comment (150-word limit) *(Required)*

39 What do you perceive to be the issues with the current investigation process as applied in your circumstance? Please comment (150-word limit) *(Required)*

40 What improvements could be made to the current investigation process? Please comment (150-word limit) *(Required)*

41 What do you see as the failures of the current document? Please comment (150-word limit) *(Required)*

Section 8 – Further Comments

42 Other comments you may wish to make regarding the MHPS process. (150-word limit) *(Required)*

Appendix F

Findings

Appendix F.1

Previous Reviews

Review of MHPS 2011-2013 (First Review)

The first review of MHPS started in July 2009. The basis for the review was part of the Confidence in Care programme, led by the Department. The reason for the review at that time Medical Directors were feeding back that the process was 'clunky' and took too long, as it allowed legal representation for doctors at an early stage of the process, which caused significant delays in addressing the concern.

It had been the intention of the then Confidence in Care Programme to revise the document that would reflect the changes to medical regulation, namely the role of the Responsible Officer and the implementation of a system of Revalidation.

The first review was taken as an opportunity to update the MHPS document, refine the processes and guidance, incorporating lessons learnt from implementation of the current procedures, and from recent events. Suggested amendments were follows, Clarification over the treatment of adverse incidents; An update on good investigation practices; Updated definitions of roles and responsibilities in MHPS; and Clarification on steps in the MHPS decision-making process.

The legal opinion of 29/3/11 from Paul Epstein QC was available to the reviewers at the time[15]. It was a legal opinion that was provided to the then Department of Health in England in respect of its MHPS document. It discusses the following questions: Is MHPS automatically part of medical professionals' contracts of employment; Unfairness in the Employment Tribunal: Unfair Dismissal Claims; Particular parts and paragraphs of MHPS and Employment Tribunal fairness and Interim Relief. If these issues were of note to the English Department of Health and its version of MHPS, then these would also have been issues for consideration in respect of the Northern Ireland version.

The key aims of the first review was to:

[15] http://www.cloisters.com/news-pdf-downloads/maintaining-high-professional1standards-in-modern-nhs-2.pdf

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

The review did not result in a final, published revised version of MHPS.

Review of MHPS 2018 (Second Review)

The second review commenced following a letter from the then HR Director at the Belfast Trust to the Department highlighting that the practical application in parts had become increasingly more difficult with the result that cases were taking an inordinate and unacceptable amount of time to progress. Trusts were then asked to provide the Department with an indication of the issues with the document and responses were received from 4 organisations. No further work was carried out on the review.

The overall aim of the second review was that it was felt that it was important that Trusts can take quick, effective and appropriate action when there are serious concerns about a doctors' performance or conduct. Confidence and trust in the capability and conduct of medical staff must be at the heart of everything that the HSC do. The second review found that the findings of Mr Justice O'Hara's report of the Inquiry into Hyponatraemia related Deaths[16] only serve to emphasise this. MHPS therefore needed to be reviewed urgently to ensure that remained an absolute priority and the aim should be for a procedure that is succinct, easy to interpret and proportionate to encourage frequent use for quick, early corrective or conclusive action.

[16] https://www.ihrdni.org/inquiry-report.htm

The following tables are a summary of the issues, improvements required and observations that were noted during the first and second reviews.

The Purpose	
Status of document	• The remit of MHPS was felt to be an issue, this centred on the coverage of the document in terms of which professional groups were considered to be in scope. It was pointed out that it did not include independent practitioners such as General Practitioners for example 90% of NI dentists are independent contractors.
Separate process for doctors and dentists	• acceptance by HSC Trusts of rotational Trainees involved in disciplinary processes.
Structure of document	• a need for User-friendliness of the document. • A need for Consistent terminology • The current revision of the framework was too long and should focus on the formal and informal processes, investigations and roles and responsibilities. • Separate section on managing concerns in relation to trainees would be helpful given potential for lack of clarity in relation to role of Employer and that of the Deanery & Responsible Officer. Issues arose where the Deanery may have difficulty in securing a placement for a Trainee when there are concerns about his/her performance. • framework is cumbersome with too many people involved and too many layers which means the process is very lengthy & complex. • MHPS is almost 50 pages long makes the document far too prescriptive to act as a framework

The Process	
Formal v informal	• A need for Clarification on the content around formal and informal MHPS processes. • The need to define the use of the word investigation throughout the document. May imply formal process when at the beginning of the process we are trying to establish the facts in relation to the concern raised.
Timescales	• Timescales in Framework require revision as often not achievable in practise. • The experience of MHPS investigations is that they are generally much longer than the suggested 4 weeks, given often the complexity and necessity to gather suitable evidence including patient records and seeking witness statements. The review panel at the time considered if there was anything that could add flexibility here whilst maintaining the importance of completing it as quickly as possible – to avoid Trusts running the risk of possibly being criticised for taking much longer than 4 weeks. • Timescales are dotted throughout the document in the context of investigations, exclusions and panels which require line by line attention and often are totally unachievable. This is also problematic when it is set within the context of the enormous list of senior officers required to participate, particularly on capability and appeal panels with multiple external members required.
Overlap of policies	• There was a need to highlight the importance of organisational policies for performance management of all employees e.g. disciplinary, capability, health and describe their relationship to the Framework.
Capacity	• Importance of good management skills is crucial when addressing concerns, perhaps a need for training of senior clinicians in this area when Framework finalised. • It is important to have appropriately skilled investigators who have sufficient time to undertake the investigation. It was felt this was crucial to ensure timescales were met and that practitioners who had been excluded where able to return to practice (if appropriate) as soon as possible. The importance of separating investigation from decision making should be clearer in the Framework.

Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• definition of the specific role of the Medical Director required clarification as they may be required to sit on a decision-making panel at a later stage. • the role of NCAS needs to be clearer and defined. • There was a degree of ambiguity in relation to roles and responsibilities when commencing an investigation and subsequent action if required. The role of the Medical Director/Case Manager needed clarification; when should they be intimately involved in cases and when they should be made aware? Their role in relation to decision making is crucial, as is the obligation placed on them to accept and act on the findings of an investigation. • Some of the case law around doctors and MHPS makes reference to the independence of panels and the review panel considered if there should be further guidance around this to protect Trusts. • Clarification of the role is needed especially of the role of NCAS and on the role of the Case Investigator when the Trust Disciplinary process is initiated. Normally the Investigating officer is also the presenting officer at the disciplinary hearing however under MHPS, the Case Investigator is purely a fact-finding role. Trusts felt they were unsure if the presenting officer should then be the Case Manager?
Accompaniment and Representation	• Issues in relation to representation needed to be addressed, including the consequences of delay arising from early legal representation. • the review team found that as soon as an investigation was launched the doctor would contact the MDU (often directed by the BMA). The MDU would almost always engage with solicitors who will immediately start a chain of correspondence directly with the Trust HR Manager on the case. Although the doctor would be accompanied at hearing by the MDU, the representative is simply presenting the case on behalf of the solicitors. Therefore, in reality the doctor is legally represented from the outset, with solicitors generating a lot of correspondence directly with the HR Managers throughout the investigation. As Trusts don't generally involve their own legal advisors at an early stage in cases (unless warranted), this correspondence often has to be responded to by (non-legal) HR Manager working with the case investigator on the case. • The MHPS framework entitles the doctor to be accompanied by a Friend – but it was felt this was fairly vague/broad and it would be helpful if further guidance around the definition of a

	‘friend’ was provided as currently it could cover just about anyone provided, they were not being paid for their assistance. Therefore, further clarification on this, even confirming they cannot be paid would be helpful for the revised document. • The inclusion of legal representation throughout the process is also out-with what is afforded to all other NHS employees. Again, the entitlement to professional legal representation throughout leads to many cases being delayed and disrupted by solicitor letters and legal argument.

Appendix F.2

Inquiries

Independent Neurology Inquiry

The establishment of an Independent Inquiry was announced by the then Permanent Secretary of the Department of Health in May 2018. The then Minister for Health, Robin Swann, converted the Independent Neurology Inquiry to a Statutory Public Inquiry on the 11 December 2020. The Inquiry Panel carried out an independent statutory inquiry of an inquisitorial nature. The report of the Independent Neurology Inquiry[17] was published on the 21st of June 2022 and included a total of 76 recommendations. A number of recommendations identified in that report directly related to MHPS and to how the HSC more widely deals with the raising and investigation of concerns surrounding an individual's clinical practice.

Of particular note is the conclusion of the 'Independent Neurology Inquiry: Report June 2022. Volume 3'[18] paragraph 13.45(iii), page number 196, that "The intricacies of the Maintaining High Professional High Standards ("MHPS") procedures make dealing with doctors in difficulty a more cumbersome process than should be the case." This finding clearly chimes with some of the issues that had been raised in the reviews that were begun by the Department in 2011 and 2018.

A further challenge noted by the INI was that the present informal process within MHPS was considered to be opaque which led to different doctors taking different approaches to investigation. The INI also considered that the present balance of the procedure is weighted towards the protection of the doctor and in the confidentiality of the process rather than patient safety.

The Independent Neurology Inquiry Panel recorded its view that reform of the existing MHPS procedure is long overdue.

[17] https://www.neurologyinquiry.org.uk/
[18] https://www.neurologyinquiry.org.uk/sites/ini/files/INI%20Final%20Report%20-%20Volume%203%20-%20June%202022.PDF

Recommendations

The Inquiry made three specific recommendations (recommendation 16-18) to the Department in relation to MHPS.

The recommendations were:

Recommendation 16: The NI Department of Health should ensure that the confidentiality dimension of the MHPS process is always subordinate to patient safety considerations.

Recommendation 17: The NI Department of Health should review paragraph 39 of MHPS and issue guidance on the appropriate balance between confidentiality for the clinician and safety for the patients.

Recommendation 18: The NI Department of Health should oversee the establishment of a group to consider the balance between the fair treatment of clinicians and the safety of patients under MHPS. The group should focus on reducing the complexity of processes and re-evaluating the degree of confidentially. The group would benefit from input from appropriate experts to include Human Resource expertise and Medical Directors.

The report also made 2 recommendations in relation to information sharing which the MHPS review may have an interest in or can provide insight or contribution to. The Department requested the panels consideration of these:

Recommendation 11: The NI Department of Health should oversee the putting in place of a formal protocol to assist clarity of understanding and timely sharing of information between Independent Healthcare Providers and Responsible Officers. The overriding objective of the protocol should be to enhance patient safety through a consistent spirit of openness and transparency.

Recommendation 22: The NI Department of Health should issue guidance to healthcare organisations about the information to be given to patients when a clinician's practice is restricted in any way.

The report made four recommendations for healthcare organisations which touch on the MHPS framework, it is therefore imperative that these are considered as part of the review to ensure the recommendations continue to be met:

Recommendation 27: Healthcare organisations should recognise that when it proves necessary to restrict part of a clinician's practice, then there may or may not be implications for other aspects of his/her practice. Healthcare organisations should take immediate steps to assure themselves that other aspects of the practice are safe, and if in doubt, should restrict the whole practice until the necessary assurance has been gained.

Recommendation 28: Healthcare organisations should ensure that in the event of any form of restriction being imposed on a clinician, the GMC is immediately informed of that restriction.

Recommendation 41: Healthcare organisations (employers) Boards, or at least one designated nonexecutive member of a Board, should be made aware of the fact that a consultant has had their practice partially or wholly restricted. (In some circumstances this requirement may be met by the MHPS process).

Recommendation 45: Where a healthcare organisation establishes any committee or group to assist with the management of concerns in relation to a clinician's practice, they should ensure that it has clear terms of reference, robust processes and a widespread understanding of their remit and role. Adequate minutes should be retained detailing the decisions taken and clearly setting out any action points arising. If the role of the Committee is advisory, then this should be made clear in the terms of reference, with particular clarity in relation to whom the Committee is advising and whether, in any circumstances, it has executive responsibility. Any clinician whose practice is being considered at such a group or committee described above should be informed and provided with appropriate details.

Confidentiality

On reading the INI report the issues appears to arise predominantly from organisations and witness representatives citing confidentiality as a basis for not providing material to the Inquiry (mostly not related to MHPS) and the representatives of Dr Watt asserting "the MHPS process is confidential".

There are 7 references to confidentiality in the document. Taking the specifics of para. 39 first – it references and was solely meant to reference the issue of any public statement regarding a (formal) investigation. The subsequent para. References

familiarity with the DPA (of course pre-dates GDPR). Other references relate to formal disciplinary procedures or Occ. Health assessments. Notably, para 38 of section IV states "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."

Urology Services Inquiry

The establishment of the independent public Urology Services Inquiry[19] was announced in a statement by the then Health Minister, Robin Swann, on 24 November 2020. MHPS features in its Terms of Reference, and it has made a number of observations on the current MHPS framework.

During his statement to the USI, DoH Permanent Secretary Peter May, stated that a rapid and fundamental review of MHPS must be started and, most importantly, completed – as soon as possible and as a matter of priority. He also noted that he would expect a future review of MHPS to consider whether MHPS should be extended to also include Pharmacists (not just Doctors and Dentists) directly employed by HSC organisations.

The inquiry was advised of the limited operational role in the application of MHPS that the Department holds covering only the following issues:

- review of longer-term exclusions (see table on pages 19-20, and paragraphs 30 and 31 on page 19, of MHPS).
- (b). the recruitment and selection of appeals panels in clinical performance cases (see Annex A of MHPS on page 35); and
- (c). provision of process advice to smaller HPSS (now Health and Social Care) organisations, where necessary (pages 41-42 of MHPS).

The inquiry held a module on MHPS which completed in June 2023.

[19] https://www.urologyservicesinquiry.org.uk/

The following tables are a summary of the observations that were noted during the USI module.

The Purpose	
Structure of document	• The Framework is cumbersome, difficult to follow and no clear structure. • Some specific areas needed to be clarified such as working privately when excluded from HSC employment. • there should be a link between the MHPS and SAI process and vice-versa.

The Process	
Timescales	• Four weeks is not a viable timeframe to conduct and complete and MHPS investigation.
Capacity & Capability	• lack of training and this should be included in rewritten MHPS guidance.

Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• Confusion and lack of understanding on the duties and areas of responsibilities within an investigation. • For medics it is time consuming and due to workloads is unrealistic; non-medics find the process stressful. • The role of co-workers in covering for an excluded clinician should be acknowledged. It is important to communicate with the team who will need to cover during the absence, and to advise them of any changes in the excluded person's role when they return.
Case Investigator	• viability of MHPS investigations being conducted by a regional team with MHPS expertise.
Accompaniment and Representation	• if the person is legally qualified, they cannot legally represent the respondent, it is perceived as potentially 'uncomfortable' for those conducting the investigation.

Other areas	
Culture	• The culture existing within Trusts and the scope of the MHPS review that the Department may wish to consider.

Appendix F.3

Approach to managing concerns in other jurisdictions.

England

The NI document was modelled on a document titled "Maintaining High Professional Standards in the Modern NHS"[20] which was first issued in December 2003 by the English Department of Health. The framework consisted of two parts: Part I: Action when a concern arises; and Part II: Restriction of practice and exclusion. In 2005 England launched the remaining three parts of the framework covering new disciplinary procedures for doctors and dentists employed in the NHS. These are: Part III: Conduct hearings and disciplinary matters; Part IV: Procedures for dealing with issues of capability; and Part V: Handling concerns about a practitioner's health.

Wales

In Wales, their document "Upholding Professional Standards in Wales"[21] was issued in 2015. This procedure sets out the approach for addressing concerns about capability, performance and conduct for all doctors and dentists employed by Local Health Boards or other NHS organisations in Wales.

It replaced all existing procedures in operation within the Local Health Boards and NHS Trusts in NHS Wales.

The procedure applies to all practitioners, which covers all doctors and dentists employed in LHBs or NHS organisations in Wales including those in training and on temporary, locum or honorary contracts and comprises of five parts:

I. Action when a concern arises.
II. Restriction of practice and exclusion from work.
III. Handling concerns about a practitioner's health.
IV. The Standard Procedure.
V. Extended Procedure.

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20 https://webarchive.nationalarchives.gov.uk/ukgwa/20130123204228/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

21 https://dhcw.nhs.wales/files/key-documents/policies/workforce-and-organisational-development/all-wales-upholding-professional-standards-in-wales/

The document advises that all NHS organisations, in their response to performance concerns, will ensure that due account is taken of the potential relevance of the practitioner's health, system failure and the working environment. The application of the procedure will be considered in conjunction with the relevant organisation's incident reporting or investigation systems. Where possible, NHS organisations will seek to address capability and/or performance concerns through training or other local remedial action. The organisations will continue to support practitioners in their professional development, through appraisal, GMC/GDC guidance and other relevant local or Welsh Government processes.

It states that the role of the Welsh Government (WG) in monitoring the effective implementation of this procedure will be coordinated through the Workforce and OD Division and any others as appropriate. Detailed arrangements for practical operation of this procedure will be notified to employers in NHS Wales directly by the Workforce and OD Division.

The NHS organisation will ensure that this procedure is operated in a way that does not discriminate on the grounds of any protected characteristic as defined in the Equality Act 2010.The NHS organisation will seek to ensure that all those involved in the operation of this procedure have been appropriately trained, including in particular those undertaking investigations and sitting on any relevant panels (which will include equality training).

4.4.2 Scotland

Scotland do not currently have an MHPS document or similar, though they have commenced a working group to look at how they manage performance concerns of doctors and dentists. The following circulars detail how professional conduct or competence is currently managed in Scotland for medical and dental staff. These are similar procedures to what MHPS replaced in England and Northern Ireland:

- 1990 (PCS) 8 "Disciplinary procedures for hospital medical and dental staff, community medicine staff and doctors in public health medicine"[22].

[22] https://www.publications.scot.nhs.uk/files/pcs-1990-08.pdf

- 1990 (PCS) 32 “Disciplinary procedures for hospital medical and dental staff, community medicine staff and doctors in public health medicine”[23]
- PCS (DD) 1994/11 “Disciplinary procedures for hospital medical and dental and community medical staff”[24]
- PCS (DD) 1999/7 “Report of the Short-Life working group on suspension of medical and dental staff”[25],
- PCS (DD) 2001/9 “Discipline Procedures: Classification of conduct”[26]
- PCS SGHD/CMO (2013)22 “Suspension of medical and dental staff”[27]

[23] https://www.publications.scot.nhs.uk/files/pcs-1990-32.pdf
[24] https://www.publications.scot.nhs.uk/files/pcs1994-dd-11.pdf
[25] https://www.publications.scot.nhs.uk/files/pcs1999-dd-07.pdf
[26] https://www.publications.scot.nhs.uk/files/pcs2001-dd-9.pdf
[27] https://www.publications.scot.nhs.uk/files/cmo-2013-22.pdf

Appendix F.4

Mersey Care

Mersy Care[28] has been cited as an exemplar of Just and Restorative cultural reform and as such the review panel took the time to meet with relevant individuals within Mersey Care and examine the impact of their approach. The engagement covered what Just Culture is, why a Just culture is required and the detail on Mersey Care's journey and the impact and benefits of a Restorative Just Culture can have on the HSC.

The goals of Restorative Just Culture are moral engagement; emotional healing; reintegration; organisational healing and creating psychological safety.

What is Restorative Just Culture?

Restorative Just Culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm

Sidney Dekker

It was noted that in developing a non-punitive culture Learning can only flourish when responses to mistakes are compassionate; Personal responsibility and professional accountability drives the organisational learning; It's not about 'blame-free' or being tolerant of absolutely anything; It's a careful balance of accountability and learning; It distinguishes between causation and contribution and work done V work imagined; A prospective outlook rather than retrospective bias is important and individuals and

A just culture accepts nobody's account as "true" or "right" and others wrong… Instead it accepts the value of multiple perspectives , and uses them to encourage both accountability and learning"
…Sidney Dekker

[28] https://www.merseycare.nhs.uk/working-us/our-just-and-learning-culture

organisations should ask what and how, not who because a bad system will always beat a good person.

There are benefits for senior leaders, employees, patients the organisation as a whole and for the policies and procedures by adopting a restorative just culture approach. In regard to the policies and procedures it means they take a co-produced approach to their production, issues are reduced in numbers, people are put before the processes, there is a focused compassionate HR and patient safety systems and processes and there is a shift in judgemental language.

Mersey Care discovered when a restorative just culture was introduced into their organisation that disciplinary investigations decreased by 71% from 2016 to 2022 and disciplinary suspensions decreased by 89% in the same period. Staff also indicated that they felt safer raising concerns about unsafe clinical practice.

Appendix F.5

HSC engagement

As detailed in the main report, the review panel collected data, received written submissions and had a deep dive engagement with HSC organisations. Similar issues and views of MHPS came up in all sessions. It was agreed by all that in 2005 MHPS was welcomed and relevant at that time. As time has progressed now the general view is MHPS is good on paper but there are some changes needed especially around the emphasis of protecting patients.

The following tables are a summary of the issues, improvements required and observations that were noted from the written submissions and the engagement sessions with HSC organisations.

Organisations within Stakeholder Group		**Range of professions within Stakeholder Group**	
BHSCT	PHA	Board Members	Medical Management
BSO	RQIA	HR Directors	Postgraduate Dean
NHSCT	SEHSCT	HR Management	Responsible Officers
NIAS	SHSCT	Medical Directors	Controlled Drug Accountable Officers
NIBTS	SPPG		
NIMDTA	WHSCT		

The Purpose	
Separate process for doctors and dentists	• worth considering one MHPS process for behavioural issues as core values are the same across all staff groups. • performance is more complex, and capability is difficult to manage and therefore may still need a regional policy. • Conduct and capability need to be clearly defined. • Equity – two-tiered system. Many regulated professions across NHS, why are doctors and dentists separate?

The Process	
Formal v informal	• terms ‘informal’ and ‘formal’ are not the correct language to be using. • informal element being de facto formal, and some have organisations adopted an initial “screening” element (possibly drawn from regional conduct procedure) as a work-around. • This screening tool/process could be rolled out and would encourage streamlining, prevent repetition and encourage quick management. • on occasion it was felt there was a level of abuse whereby preliminary enquiries are prolonged. • Early conversations with practitioners are required to maintain high professional standards and to help prevent escalation with early support. • Early agreed outcomes are needed.
Exclusions/suspension /restrictions	• Because of how doctors work a way to exclude them needs further defined. • It can lead to de-skilling for those who are excluded. • there is an impact on the rest of the team with workload while the staff member is excluded and also the integration back into the team on their return.
Timescales	• a prolonged time is taken and is not acceptable. • it leads to a protracted journey for all involved. • these delays have an impact on the team as a whole as well as the individual. • police involvement can often delay the process as trusts will often wait on the police process concluding and they have no control over this. • Accountability should be taken for those causing delays on both sides. • those with specific roles within MHPS have limited time and capacity to carry out their role. • Suggestions for revised timescales ranged from 5 weeks to 12 months. • Agenda for Change procedures offer a much simpler and time efficient process. • Notice of 6 weeks for clinicians to attend causes huge delays – this does not marry up with 4 weeks for completion.
Overlap of policies	• The problem with the current MHPS lies with dual processes – MHPS and e.g. whistleblowing, disciplinary & conduct policies, the question needs asked of which one has primacy? This leads to confusion about how MHPS sits alongside conflict, Harassment and Bullying issues – especially when involving both medical and non-medical staff.

	• Confusing, as general employment laws apply when ending up in tribunal. Therefore, does the MHPS process 'muddy the waters'. Where does it sit with Statutory Dispute Regulations.

Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• Role clarity around responsibilities is needed. • a flowchart with clear hierarchy and steps would be welcome within the document. • there is a lack of experience and knowledge of MHPS and therefore appropriate relevant regular training is required. • Independent people are needed. • Infrequency of cases means unfamiliarity – merit in having a regional dedicated team who have the necessary knowledge, skill and experience in MHPS roles, which will also remove duplication across trusts. Caution was noted however as the employer must retain the overall responsibility.
Chief Executive	• Chief Execs should not be involved.
HR	• The Case Manager and Case Investigator are busy and need HR support. • HR sometimes struggle – as they are not experts on this.
Case Investigator	• Central resource of investigators would remove bias. • The employer should retain ultimate decision making with regards to suspensions and dismissals etc. under Statutory Law. • finding an appropriate expert to take part in the investigation with no conflict of interest can take time.
Accompaniment and Representation	• Legal representation was noted as being an issue especially early on in the process as it can frustrate the process and prolong it unnecessarily. • The process allows people to bring along legal representation (who are there to observe only) – once this happens there is a legal mindset which often hinders a resolution.
Support	• Rapid support is lacking but there is support available both internal to HSC and external and would include: Trade Union Side – also being mindful of a group of doctors who are not members; Within each Trust there are bespoke Occupational Health arrangements; PPA; GMC; NHS Practitioner Health Programme; and Doctors and Dentists AA

	• Outside of the wellbeing support there needs to be a clear understanding about the expectations of the process. • support should be non-judgmental. • medical staff tend to be resistant to seek support proactively. • Adequate resources are needed for supporting doctors and also those handling the case.
Confidentiality & sharing of information	• The confidentiality rules add complication, whilst other processes require openness and transparency.

Oversight, Governance & Accountability	
NED	• not a need for NEDs or Board members to be involved. • It should be a private process - why should doctors and dentists be singled out by being brought to the Board. Another committee could look at these things.

Other areas	
Complexity and Consistency	• Confusion around whether cases should be dealt with under MHPS or not. • a lack of consistency of approach across the region
Culture	• early stages of adopting 'a just culture' approach which leans towards a restorative and not punitive attitude. • there is a 'weaponisation' of processes, a culture where doctors are afraid to speak out, due to a fear of being reported/targeted. • Where does it fit going forward within the wider community with an open, just and learning culture. It must link across to everything that is done. • Should be about learning and education and not punishment – perception of staff is essential. • Good community can help discourage poor behaviour.

Appendix F.6

Trade Union Engagement

The Review Panel received written submissions and also met with the BMA, BDA and HCSA to gather their insight into the process. The following tables are a summary of the issues, improvements required and observations that were noted from the written submissions and the engagement sessions with Trade Union representatives.

The Purpose	
Status of document	• Well intended document
Separate process for doctors and dentists	• No need for a separate process • Brings in equality issues for separate processes
Structure of document	• Needs simplification. • Protracted processes

The Process	
Formal v informal	• ensuring the process is necessary from the outset when a potential issue arises
Timescales	• must be timebound and timescales adhered to • The current timescales are being failed to be met and therefore are not realistic. • The initial part of investigation should be dealt with quickly and when extensions to deadline are required then applications should be made for an extension and the individual be part of process. • None of the organisations were able to indicate what they felt the timescales should be. • Timescales need to be realistic and not too prescriptive as flexibility could be needed in cases with more witnesses etc or of with cases of greater complexity in general.
Overlap of policies	• Significant delays are made over fear of whistleblowing. • felt by employees that MHPS has been weaponised against employees who raise patient safety concerns to the extent there is a general perception that if an employee raises an issue, they become the object of unwarranted Preliminary Enquiries and Investigations.

Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• making clear the roles and responsibilities of all involved • ensuring that they are adequately trained. • poor and inconsistent communication
Case Investigator	• Finding an appropriate expert with no conflict of interest can take time (NI is limited geographically). • There is a need for independence within the framework and case investigators. • Use external investigators to prevent delays and improve speed.
Case Manager	• Where an internal case manager is used sessions should be included in job planning as appropriate. • Inexperience of case managers is an issue – they require better training and access to more immediate support.
Accompaniment and Representation	• preferable to keep legal representation out of the informal process as engaging legal representation can prolong the process and also creates an unnecessarily adversarial tone to proceedings. • The legal minimum standard is for accompaniment in a formal grievance or discipline meeting/hearing and as such the right of representation in an informal process is a collectively agreed gloss on the law that oftentimes becomes more hindrance than help.
Support	• Little or no support

Oversight, Governance & Accountability	
Governance	• significant issues around the governance architecture
NED	• The role of designated board members should be enhanced to ensure they are trained and equipped to operate as honest brokers in the application of all aspects of the framework.
DoH	• Ownership of the policy/framework must rest with the DoH and not individual trusts. • The role and authority of the DoH should be enhanced to include a mechanism for enforcing the framework and the accountability of trusts.

Appendix F.7

Engagement with professionals subject to the process

A hallmark of success in any policy is ensuring the member of staff who is subject to the policy feels the process was carried out fairly and consistently and the outcome was fair and balanced. The professionals who were subject to the process and provided information to the review team provided consistent reflections on how the process is implemented in Northern Ireland based on their own personal experiences. The Questionnaire ran from 22/11/2023 to 06/12/2023. 32 were invited to provide their views, submissions were received from 15 individuals.

The Review Panel identified a number of themes after reading the views and experiences of the individuals. The panel took into consideration that all the responses came from one Trust and were all of consultant or equivalent grade which could potentially skew whether the views are representative of all medical staff throughout Northern Ireland who have been through the process or whether the results reflect more the perceived culture and processes of one Trust or one grade. The panel concluded that as they had heard similar issues raised through wider stakeholder conversations, they could take the view that the views expressed are representative.

The personal and human impact of the process is not something that is lost on the review panel.

The following tables are a summary of the issues, improvements required and observations that were noted during the noted from the written submissions from those professionals who have been subject to the process.

The Purpose	
Separate process for doctors and dentists	• The majority of cases (69%) were of a behavioural/misconduct nature, this is also backed up with the evidence supplied by the PPA and the HSC organisations. 94% of all respondents had a behavioural/misconduct element to their investigation. • 44% of respondents felt there was a need for a separate process for medical and dental, 31% stated there was no need and 25% did not have a view.

	• Any process needs to be applied fairly and consistently to all staff. • There should be a specialist review that understands the peculiarities of medical decision making but this is no different than reviewing a staff member who has an unusual or specialist job role. • The process of MHPS is fine, it's the application of the process is the issue. • A separate process is preferable. The individuals subject to these investigations are independent practitioners and it may not be appropriate to have the same process for all HSC staff. • Subsuming MHPS into one process for all, HSC is dumbing down the extraordinarily long and arduous training consultants endure to lead healthcare teams. • Non-clinical managers are not qualified to make judgement on clinical matters, but clinical experts are not employment law experts, and the process must follow all tenants of employment law. The key is to have the appropriate people investigating as many do not have the knowledge or understanding of the situation - clinical and non-clinical.
Structure of document	• as the document was written 20 years ago it was outdated and was too long and woolly • Improvements to the document itself would be from getting senior medical/trade union/employment lawyer inputs in document and reviewing it every five years with engagement from doctors, those investigated, the PPA, medical defence unions and employment unions. • as there is no guidance/process for the informal/preliminary proceedings and that the document should contain this and examples.

The Process	
Formal v informal	• blurring between informal and formal processes. • unclear when informal should become formal and that those responsible for enacting the process did not seem to understand the difference either. • escalation from informal to formal was a vindictive and unwarranted response. • Terms of Reference for either the informal or formal stage not being issued to those subject to the investigation.

Exclusions/suspension /restrictions	• 63% of respondents had temporary restrictions placed on their practice, 37% did not have any restrictions placed. Of those who had temporary restrictions placed on their practice, 89% were informed as to the reason for the temporary restrictions. • Of those who had temporary restrictions placed on them 50% had restriction of all clinical duties imposed. The other 50% either had leadership roles revoked or they were not allowed to supervise or have exposure to trainees. • Immediate restrictions were imposed contrary to GMC advice. • Being restricted and not excluded meant there was no obligation on management to formally review the situation and it was allowed to drag on over years.
Timescales	• concerns about the timelines and adherence to the stipulated timelines. • 69% took more than 12 months to complete with 6% remaining uncompleted. • Of the ones that took more than 12 months, 40% advised it took between one to two years to complete, 20% two to three years to complete and 40% three to five years to complete. • The protracted length of time taken for the process can affect health, morale, good working relationships and working days lost to the organisation. • Improvements to the timescale's issues were suggested as follows: o Timescales should be adhered to and enforced by all and compliance to the timescales has to be a two-way process. o Attempt to resolve at an informal stage within a week of the event. o Fine the trust for inappropriate delays. o Requirement to complete within four weeks as required by statute unless exceptional circumstances.
Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• failure by employers to comprehend the damage and trauma they cause with these processes both professionally and personally to the individuals involved. • Staff involved are not trained appropriately.
HR	• Lack of communication
Case Investigator	• staff running/investigating the process were not appropriately trained and at times have no experience in the speciality or clinical matters they are investigating.

	• those investigators should have sought advice from those who understand the complex clinical situations they were investigating, but this failed to occur. • independent panel external to the trust should be established to carry out the investigations. • appropriately trained and have a knowledge of the issues being investigated.
Role of PPA & GMC	• an audit of the number of referrals to NHS resolution (PPA) by each HSC Trust must be taken annually and published (anonymized) for transparency. • PPA could take a more active role in MHPS by contacting the consultant, establishing the facts and/or factual inaccuracies of their case and take into account the doctors legal rights. If it, then materialised there is any doubt regarding the validity of the concerns the PPA should pause the proceedings and inform the Trust the legal basis for doing so. • "Fitness to manage" proceedings akin to "fitness to practice" proceedings to be developed by GMC.
Support	• The majority of individuals (75%) were offered support during the process, but this mainly took the form of being signposted to OHS. All agreed that the support offered needed to be improved. • following improvements on the support offered would make the process a less isolated experience for this involved: o Regular, frequent and clear updates and explanations on the process and progress of the investigation including consistent and regular support from management/clinical colleagues. o An advocate put in place who would act for those under investigation. o Fair and reasonable advice given by employers. o Employer having an understanding of the damage and trauma these investigations can cause. o Behaving humanely instead of bullying emails. o External neutral arbiter being put in place. o Support from somebody other than line manager.
Confidentiality & sharing of information	• Reason for initiating the process may be unclear and subject to bias. • Factually incorrect reports.

Oversight, Governance & Accountability	
Governance	• process is unregulated. • a need for regular reviews of the process while it is ongoing.

	• audits should be carried out and made freely available. • HSC Trusts should be fined if an investigation has been commenced inappropriately.
NED & Board	• no oversight of the MHPS Investigation Team by the Executive Board. • Any nonexecutive board members who are involved are inexperienced though on many occasions there was a failure of the appointed Non-Executive Director to engage or to oversee any concerns
Levels of accountability	• oversight is that is mainly lacking. • failure to provide a completed final investigation report and there was no audit of concerns raised about the process, nor were the concerns investigated. • a failure to permit or provide the affected clinician with an opportunity to raise concerns about the MHPS investigation.

Other areas	
Complexity and Consistency	• inconsistency in the implementation of the process within the HSC Trusts and some felt the policy was incorrectly used and weaponised against them and it did not seem to be a fair, open and transparent process.
Culture	• The current MHPS process does not promote the just and open culture everyone wishes to see within HSC. • The lack of insight into the effect that the investigation has on staff and the presumption of guilt of the individual from the outset. It is an adversarial and not focused on learning and development.
Outcomes	• 88% of respondents their MHPS process did come to a conclusion though 12% never did. Of those that didn't come to a conclusion, 33% were advised why and 66% were not advised the process was not able to be completed.

Appendix F.8

PPA Engagement

NHSR is an Arm's Length Body of the Department of Health and Social Care in England. It has four key service areas:

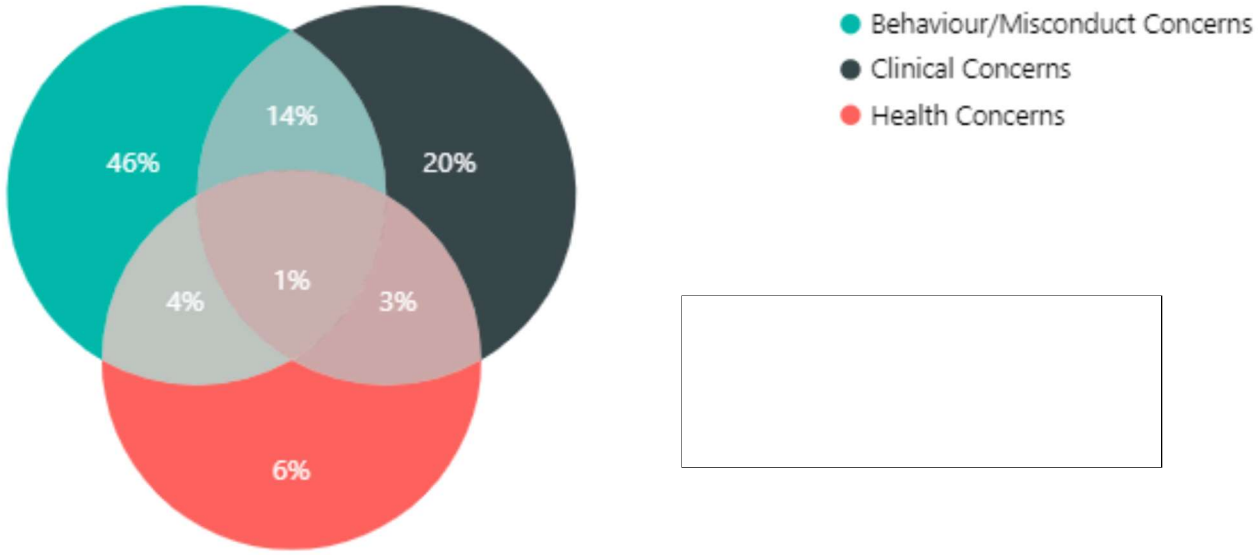
- **Practitioner Performance Advice**: providing advice, support and interventions in relation to concerns about the individual performance of doctors, dentists and pharmacists.
- **Claims Management:** delivering expertise in handling both clinical and non-clinical claims to members of our Indemnity Schemes.
- **Primary Care Appeals**: offering an impartial resolution service for the fair handling of Primary Care contracting services.
- **Safety and Learning**: supporting the NHS to better understand and learn from claims; to target safety activity while sharing learning across the NHS.

Practitioner Performance Advice ('Advice service') (formally NCAS) was established in 2001 and is now a service delivered by NHSR under the common purpose to provide expertise to the NHS on resolving concerns fairly, share learning for improvement and preserve resources for patient care. It uses national frameworks, guidance, and standards to underpin and inform its work. The Advice service provide a range of core services to NHS organisations and other bodies in England, Wales, and Northern Ireland such as advice, assessment and intervention, education, insights and healthcare professional alert notices to support organisations to effectively manage and resolve concerns raised about the practice of individual practitioners. It provides the Advice service under a service level agreement with the Department of Health in Northern Ireland. A high-level review of cases supported by Practitioner Performance Advice in secondary care in Northern Ireland over the last 5 years was provided to the panel for consideration as context of the work and expertise of the PPA.

Key facts which were noted from this were that between 2018-2023 153 secondary care cases were opened, the majority of which were from the Belfast Trust. The majority of cases were male consultants over 45 years old with more than 10 years in post.

The natures of the cases can be seen in the below diagram, and it can be noted that cases can have more than one concern associated to them. 65% of all cases had a

behavioural element reported, 38% had a clinical concern reported and 14% of cases had a health concern reported.



The NHSR overall view is that the MHPS framework should ensure a timely, fair, and consistent approach to handling concerns across all organisations, based on the principles of early intervention and remediation, to help return the doctor or dentist to safe and effective practice as soon as possible. The consistent use of MHPS also ensures that organisations are relying on existing precedent and case law, reducing the risk of litigation. The NHSR believes a national framework supports the promotion of proportionality, fairness and good practice, strengthening confidence in the process which improves the quality of the management of concerns. It is expected that local trust policies and procedures (including those relating to misconduct) complement MHPS, ensuring that MHPS is used only where the conduct relates specifically to professional misconduct.

MHPS is underpinned by several key principles which NHSR believe need to remain important. These are:

- consistency across HSC organisations
- a focus on early, informal resolution and remediation
- clarity about key roles and responsibilities in the process

- a high threshold for exclusion from work and closer management
- support for staff and access to specialist advice.
- a framework for assurance and oversight.

Whilst the NHSR recognise the need for a framework to manage concerns, they also feel it is important to emphasise that an effective organisational culture can prevent concerns arising in the first place. This includes having the right recruitment procedures, induction, training and support, effective appraisal, line manager training, inclusion and diversity, freedom to speak up and support for physical and mental health and wellbeing.

The PPA also provided more detail feedback on the issues they perceived with the current MHPS processes and gave suggestions for how they might be improved. This feedback was informed by their extensive experience of supporting healthcare organisations in resolving performance concerns and protecting patient safety.

The feedback mainly covered the informal resolution and preliminary enquiries, formal investigations and exclusions, roles and responsibilities and governance arrangements and a consistent approach to quality assurance.

The PPA are supportive of undertaking a preliminary enquiry and would propose retaining this as part of the revised process. However, in their experience, a preliminary enquiry can take a substantial amount of time and as such suggested that a timescale is included in the document to advise on how long the enquiry should take, and when a formal decision should be taken. Further to this, where a preliminary enquiry identifies misconduct, PPA suggested that the organisation moves to enact their local policy for management of conduct cases. This reflects the view that conduct that any staff member is capable of should be managed via a local process, whilst MHPS remains available where the conduct relates specifically to professional misconduct and therefore it may be helpful to provide a definition of professional misconduct.

The PPA, where a formal investigation is required, are supportive of the practitioner having the opportunity to comment in writing on the factual content of the report produced by the case investigator, as it gives the practitioner the opportunity to respond and provide any further comments as necessary. They also suggested that

the use of “informal” and “formal” stages should be removed from the document, as in their experience, both stages can be perceived as formal in nature by practitioners. Similarly, reference to “immediate exclusions” and “exclusion other than immediate exclusion” may also cause similar issues. Instead, the PPA exclusions should be referred to as a whole.

Under roles and responsibilities, they recommended that the revised document explicitly states that it relates to doctors in training as it does for any other practitioner. In the *guidance on conduct hearings and disciplinary procedures* it does not make direct reference to doctors in training (which differs from the MHPS in England, which includes a paragraph encouraging that allegations of misconduct against a doctor or dentist should be treated initially as a training issue and dealt with via an educational supervisor).

Finally, the PPA noted that is MHPS refers to a wider management framework which includes robust governance arrangements and a consistent approach to quality assurance. This should include arrangements for reporting concerns within the individual organisation incorporating robust escalation procedures which can also be used to escalate any concerns or issues in relation to perceived organisational culture. The PPA recognise that maintaining confidentiality should be maintained as far as possible however we are of the view that patient safety will always be paramount, and in some instances, it may be necessary to share information to prevent patient safety incidents from occurring. Complex issues such as these are never binary, and it is recognised that each case presents its own challenges. It is therefore suggested that the MHPS ensures that reference to reporting concerns is to protect patients whilst also being fair and supportive to the practitioner.

Appendix F.9

Regulatory Body Engagement

The GMC and GDC provided written submission to the Independent Review panel and the GMC met with the panel to discuss their thoughts in more detail.

The following tables are a summary of the issues, improvements required and observations that were noted from the written submissions and the engagement sessions with the Regulatory Bodies.

The Purpose	
Status of document	• Important that local processes are fair, consistent, and robust. • clarity on the purpose of the current framework and the rationale for having a separate process for managing concerns about doctors (and dentists) to those for managing concerns about all other professionals and HSC employees. • unsure if the current framework is sufficiently flexible to deal with emerging concerns. • current framework does not promote and is not explicit about equality, diversity and inclusion considerations which are required to address the potential for unfairness and bias with its processes. • terminology within the current NI Framework is outdated and does not reflect reforms or innovation in the system.
Separate process for doctors and dentists	• If looking at behavioural issues, personal issues, bullying and harassment etc – why would there be a need for a separate process as these policies should cover all staff. • Clinical concerns may need a separate process. • Concern that a separate policy could isolate doctors from other staff. • With respect to doctors being able to fact check the evidence, it is important to note that other staff in the HSC do not get a similar right to reply. • perception of unfairness amongst doctors who are subject to processes that are separate to other Trust employees

Structure of document	• Need the process to be simplified, clear and transparent from the outset. • framework can be difficult to implement

The Process	
Formal v informal	• If informal is a conversation and if it is not documented, can it be relied upon later as part of a formal process. • Many doctors may be concerned that an informal process will automatically lead to a formal process. • Desire to have a 'local first' policy – where possible to address issues without the need for escalation. • inconsistency across Northern Ireland in terms of when an MHPS investigation is initiated and the interpretation of what constitutes an informal process seems to differ between Trusts. • Information about when and how to conduct an informal consideration of concerns would promote openness, transparency and learning and if progression to a formal process takes place, there should be clear and realistic expectations regarding timeframes for completion with action planning process that include opportunities to reflect and remediate.
Exclusions/suspension /restrictions	• If clinical, then what measures have been put in place to allow the doctor to return safely? • if a condition is that they can return under supervision etc – then it is dependent on the resources available in the organisation. • Issue with the medical workforce in NI in terms of numbers – the longer that doctors are unable to work due to these processes then the greater the impact on them and the teams that they work with, which then impacts wellbeing and patient safety.
Timescales	• Timescales for investigation and decisions are then often extended without clear or realistic deadlines. • A long-drawn-out process can be a risk to patients and also to Doctors, where there may be an issue of 'de-skilling' if they are excluded for a period of time. • Processes should take place as quickly as possible.

	• Getting staff back to work in a timely manner will enhance patient safety and the impact on staff will be less harmful. • Police involvement can often delay the process as trusts will often wait on the police process concluding.
Overlap of policies	• Very often clinical concerns about a doctor are accompanied by behavioural concerns, interpersonal, team difficulties etc - this may require moving the doctor to another site etc. • Concerns raised are often multi-factorial – covering conduct, performance, and health. A process that started out as a fair conduct concern can then become a health concern. This can extend the length of the process, particularly if the issues can't be addressed concurrently.

Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• Need for training for Responsible Officers, as there are often inconsistencies across NI in how processes are applied.
HR	• Did MHPS come about as a result of HR processes not understanding the role of a doctor?
Case Investigator	• challenges associated with appointing independent case investigation teams
Accompaniment and Representation	• Involvement of legal representation can cause delays to timescales.
Confidentiality & sharing of information	• Independent sector in NI is growing. If there is a clinical concern/risk to patient safety it is important that that information is shared appropriately across organisations to allow, for example, the independent sector to mirror any restrictions that have been applied. • Reluctance to share information is quite widespread across the HSC. • information sharing amongst organisations is not always carried out in a way that protects patients or supports doctors

Oversight, Governance & Accountability	
Governance	• Effective clinical governance contributes to the safety and quality of patient care and GMC handbook Effective clinical governance for the medical profession provides guidance for organisational leaders in managing, delivering and assuring the quality of clinical governance processes for medical professionals in the UK. • take account of wider clinical governance expectations within organisations and include the requirements to consider fairness and reduce bias within the process.

Other areas	
Culture	• Support being given to Responsible Officers, to help them, where necessary, to make changes to the culture of an organisation. • Concern that there is a 'weaponisation' of processes, a culture where doctors are afraid to speak out, due to a fear of being reported/targeted. • Need to change organisational cultures as doctors are reluctant to raise issues regarding patient safety. • Need to have an open and supportive culture where staff can admit to mistakes, the impact of inquiries and reviews has made staff reticent to speak. • The acceptance of MHPS, whilst focused on patient safety, will be affected by the current climate of industrial relations and industrial action. • Potential blurring between personal and professional concerns. Important that doctors and all health professionals understand that their conduct away from work impacts their work also.

Appendix F.10

Indemnity Organisations Engagement

The Review Panel met with and received written submission from the Medical Defence Union and the Medical Protection Society.

The following tables are a summary of the issues, improvements required and observations that were noted from the written submissions and the engagement sessions with Indemnity Organisations.

The Purpose	
Separate process for doctors and dentists	• moral fairness in that there is equal pressure on doctors and other HSC staff. • doctors are intently different and ultimately their registration could be at stake

The Process	
Formal v informal	• the use of prolonged preliminary enquiries without providing allegations to the doctor • The informal step is misused. • Lack of transparency early on as to what has been said causes problems.
Exclusions/suspension /restrictions	• If the doctor is excluded, they become deskilled, that is more damaging than being dismissed. • sick leave or special leave may be used to avoid exclusions. This has the effect of bypassing reporting arrangements to the board and reviews. • If there are delays and the doctor is excluded, consideration should be given to arranging a clinical placement elsewhere. • Surgeons and other craft-based specialists who are only restricted, but not operating may also benefit from a placement. • Returning to work is generally done with PPA, using an action plan.
Timescales	• Indecision leads to egregious delays. • Most stages in the policy do not have timescales, where they exist, as in any equivalent UK policy, they are not even remotely adhered to in the vast majority of cases. • Prolonged timeframes are a major issue.

Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• External input could be helpful.
Case Investigator	• The report from the case investigator should simply juxtapose what each witness says to each allegation. • The Case investigator should not waste time coming up with their own unsolicited opinions or referencing GMC guidance. • Case investigators should routinely ask doctors what they would do differently next time to help doctors reflect. • Trained case investigators need to have adequate time allocated to them, if this is not possible an independent investigator should be instructed.
Case Manager	• case managers need support in quickly drafting appropriate allegations based on what they know. • Case managers should be able to take advice from senior colleagues nationally, including PPA.
Accompaniment and Representation	• help to neutralise emotion and can often offer fresh perspective by way of preventing arguments and unproductive meetings. • They can only attend when policy allows. • Legal representation can affect the conversation once its commenced. • It depends on each individual situation as too early or too minor can make the process more formal and rigid than it needs to be. • It can calm the doctor down and give them some insight and take the heat out of the situation.
Support	• Witnesses should be assisted to schedule interviews and reminded of the urgency of the process. • There should be a nominated pastoral link to the department that an excluded doctor can talk to • a nominated consultant of the same speciality, possibly from a different hospital. Useful to have someone from the same specialty to converse with as part of the policy in contrast to information being confidential which is the current situation.
Confidentiality & sharing of information	• transparency is essential

Appendix F.11

Royal Colleges Engagement

The Review panel wrote to fifteen Royal Colleges, the following four provided written submission to the review panel for their consideration. Royal College of Surgeons of England, Royal College of Paediatrics and Child Health, Royal College of Surgeons of Edinburgh, Royal College of Psychiatrists.

The following tables are a summary of the issues, improvements required and observations that were noted from the various written submissions from the Royal Colleges.

The Purpose	
Status of document	• National framework ensures a consistent approach across Trusts and Boards, supporting them in developing their local framework, procedures and policies. Having a framework at a national level protects and quality assures the processes and all those involved in managing cases of poor performance. • Re-drafting of the framework gives the HPSS the opportunity to align it with the recent revision of Good Medical Practice from the GMC as well as reflect the changes in the structure and function of NHS Resolution and the Practitioner Performance system.
Separate process for doctors and dentists	• do not believe that there is a need for an additional Northern Ireland Framework. • the same robust, fair, safe and equitable process be followed throughout Northern Ireland. A single Framework will support this.
Structure of document	• the Practitioner Performance Advise (PPA) directorate aims and purpose should be considered extensively

The Process	
Formal v informal	• Failure to apply MHPS processes appropriately (formal and informal processes) • some MHPS processes have been opened following minimal fact-finding, leading to stress and anxiety for Clinicians, who were subsequently informed at the end of the process that a more robust initial informal process would have cleared them immediately.

	• Ensuring informal approaches are initially used and that proceeding to formal processes is done only after a thorough informal process has been followed
Exclusions/suspension /restrictions	• should be 4-week exclusion period
Timescales	• processes take far too long to complete. • Investigations into any medical professional should be completed in a timely and comprehensive manner in much shorter timeframes. • Lengthy investigations into a clinician's practice takes a negative toll and can lead to substantial mental health impacts. • reasonable timeframes are adhered to in the application of the revised Framework. • process length needs to be carefully examined and shortened.
Capacity	• develop training for cultural competence in decision making.

Roles & Responsibilities and Rights of those involved in the process	
Roles in general	• Responsibility for implementation i.e. delegation of process outside of CEO/MD • System Leaders should collaborate with NHS Resolution and other key partners to convene a cross-organisational group to help support practitioners to navigate approaches to responding to concerns which increases transparency.
Support	• senior leaders should consider utilising and signposting practitioners to NHS Resolution to provide impartial advice, to effectively manage and resolve concerns raised about the practice of individual practitioners as this enables a fair and effective application of the healthcare organisation's own local performance management, associated procedures and good practice in relation to local case management and investigation. • A focus on the wellbeing of the Clinician being investigated, with adequate support from within the Trust/HSCNI - and recognising the Trust will have a duty of care to its employee. • Ensuring that Staff wellbeing, as well as Patient wellbeing, is held at the core of this process - and that MHPS is not in itself allowed to cause avoidable harm to Clinicians

Confidentiality & sharing of information	• Patient safety should always be the primary consideration

Oversight, Governance & Accountability	
Governance	• Knowledge Matrix Strategy and robust collecting and collating of data across operational delivery, all clinical audits, Quality Improvement and learning from Serious Adverse Incidents
NED	• training for designated non-executive directors who, in Maintaining High Professional Standards (MHPS), should provide an impartial route of support to practitioners at the preliminary analysis or case investigation stages.

Other areas	
Culture	• senior leaders of health care organisations should review plans on providing inclusive and supportive environments, ensure they are evidence based, take a proactive approach, consider how assurance is given that improvements are made, and that best practice is disseminated. • Culture has been the crux of a plethora of independent inquiries into failings which have impacted patient safety or caused harm and poor culture is exacerbated within financially stretched Health and Social Care systems.

Appendix E

Data Collection from HSC Employing Organisations on MHPS Cases

Experience of the operation of the INFORMAL approach[29]

			Total
1	Number of informal investigations over 5 years adopting the informal approach commenced between 2016 & 2020 (excluding 2020 & 2021 due to covid)		96
2	Number broken down by medical or dental:	Medical	41
		Dental	2
3	Breakdown of informal investigations by grade:	Training Grade	11
		SAS Doctor/Dentist	24
		Consultant or Equivalent	22
		Other (please detail)	1
4	Number of informal investigations completed within the following periods:[30]	4 weeks	21
		1-3 months	6
		3-6 months	7
		6-12 months+	16
		Remain uncompleted	12
5	Number of informal investigations in each of the following categories:	Behavioural/Misconduct only	29
		Clinical capability only	17
		Health only	1
		Behavioural/misconduct & Clinical capability	8
		Behavioural/misconduct & Health	3
		Clinical capability & Health	3
		Behavioural/misconduct & Health & Conduct	0
6	The result of the completed informal investigations	No further action	13
		Referral to occupational health service no further action	3
		Referral to occupational health service and further referral	2
		Referral to a conduct panel	1
		Referral to a clinical performance panel	0
		Referral to GMC or GDC	1

[29] One HSC employing organisation held no records for 2016, for 2017, 2018 & 2019 they held no records centrally other than the number of investigations therefore their figure could not be broken down further than Q1. Another HSC employing organisation advised they have not historically recorded informal approaches. Hence cannot respond to this part of the questionnaire. Since the requesting similar information by the department earlier this year the trust are now recording this information for future reporting. A third HSC employing organisation advised that not all cases handled informally by managers would be captured centrally so their figures would be underrepresented, records were also not complete in that trust for 2016-2018

[30] One HSC employing organisation advised they did not keep records of timescales when informal approaches agreed following screening. Preliminary screening report would normally take up to 4 weeks or in some cases may be slightly longer.

Experience of the operation of the FORMAL proceedings[31]

			Totals
1	Number of formal investigations over 5 years adopting the informal approach commenced between 2016 & 2020 (excluding 2020 & 2021 due to covid)		44
2	Number broken down by medical or dental:	Medical	29
		Dental	1
3	Breakdown of formal investigations by grade:	Training Grade	4
		SAS Doctor/Dentist	7
		Consultant or Equivalent	22
		Other (please detail)	1
4	Number of formal investigations completed within the following periods:	4 weeks	0
		1-3 months	2
		3-6 months	12
		6-12 months	18
		Remain uncompleted	1
5	Number of formal investigations in each of the following categories:	Behavioural/Misconduct only	9
		Clinical capability only	6
		Health only	1
		Behavioural/misconduct & Clinical capability	5
		Behavioural/misconduct & Health	2
		Clinical capability & Health	1
		Behavioural/misconduct & Health & Conduct	1
6	The result of the completed formal investigations	No further action	4
		Decision by a conduct panel	15
		Consideration though health procedures	4
		Decision by a clinical performance panel	4
		Referral to GMC or GDC	13

[31] One HSC employing organisation held no records for 2016, for 2017, 2018 & 2019 they held no records centrally other than the number of investigations therefore their figure could not be broken down further than Q1.

Experience of exclusion under Maintaining High Professional Standards[32]

			Totals
1	Number of exclusions commenced over 5 years between 2016 & 2020 (excluding 2020 & 2021 due to covid)		12
2	Number broken down by medical or dental:	Medical	9
		Dental	2
3	Breakdown of exclusions by grade:	Training Grade	1
		SAS Doctor/Dentist	4
		Consultant or Equivalent	5
		Other (please detail)	1
4	Number of exclusions were discontinued within the following time periods	4 weeks	2
		1-3 months	2
		3-6 months	1
		6-12 months	7
		Remain uncompleted	1

Experience of the involvement of NHS Resolution's Practitioner Performance Advice (PPA) [33]

			Totals
1	In how many cases (whether at informal or formal stage) did you seek advice from the PPA in each of the following CALENDAR years		109
2	Number broken down by medical or dental:	Medical	93
		Dental	3
3	Breakdown of exclusions by Grade:	Training Grade	7
		SAS Doctor/Dentist	14
		Consultant or Equivalent	16
		Other (please detail)	0
4	The nature of advice:	Purely advisory	23
		Facilitated mediation	0
		Clinical Performance assessment	2
		Behavioural Assessment	5
		Action Plan/Return to Work	8
5	In how many cases was the intervention from PPA helpful in bringing the case to a prompt and satisfactory conclusion?		25

[32] One HSC employing organisation held no records for 2016

[33] One HSC employing organisation held no records for 2016. For 2017, 2018 & 2019 they held no records centrally other than the number of investigations and breakdown between medical and dental therefore their figure could not be broken down further than Q2. Another HSC employing organisation advised that they can only report on the number of cases referred to the PPA for discussion during the requested years as detailed historic records are not accessible.

stage. There's a professional appraisal process and job planning process that I understand was introduced in 2003. That was then supplemented in 2012 by the revalidation process that all Clinicians go through on a three-yearly basis that is run by the GMC, and then MHPS is something that sits, as it were, on top of and alongside those various mechanisms. The first review was in 2009. The second started in 2018. As you say, neither of those was completed. Before the Minister left, the outgoing Minister left office he agreed to proceed with a review of MHPS. We are hoping that review will commence early in the New Year. We are currently looking at identifying suitable individuals with an expertise who could come in and assist with that process. I think there were already some issues that were identified previously about the length of time it takes to get through the various steps, the clarity on roles, the need for clarity about which professional groups are covered by the MHPS process, including, for example, whether GPs and pharmacists are within the scope or not. But alongside that we have also more recently received the Neurology Inquiry report which makes further recommendations around MHPS, and obviously we'd want to take that into account. One of the things that I'm keen to do is not to see individual recommendations from Inquiries and do a kind of tick box thing but we have to kind of join it all up together because they are all part of a wider piece. We have already talked about being open, and that's

11:16 11:17 11:17 11:17 11:18

Neutral Citation No.: [2008] NIQB 143 *Ref:* **McCL7319**

Judgment: approved by the Court for handing down *Delivered:* **04/12/08**

2008 No. 101129

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

QUEEN'S BENCH DIVISION

BETWEEN:

MA

PLAINTIFF

-and-

BELFAST HEALTH AND SOCIAL CARE TRUST

DEFENDANT

Headnote

Medical practitioner – Health and Social Care Trust – contract of employment – disciplinary proceedings – disciplinary code – legal representation – Health and Personal Social Services (NI) Order 1991, Schedule 3, Part II – departmental directions – statutory duty on Trust to comply – common law right to a fair hearing – ingredients – context – propriety of injunctive relief – declaration – costs – discretion.

McCLOSKEY J

I INTRODUCTION

[1] This matter comes before the court under the guise of an application for an interlocutory injunction brought by the Plaintiff, MA, against the Defendant, Belfast Health and Social Care Trust ("*the Trust*"). The question of whether this is properly to be treated as such an application, as opposed to the trial of the action proper, in the particular circumstances of this litigation, is considered in paragraphs [5] – [7] below.

[2] This application is pursued in the following litigation context. By Writ of Summons issued on 29th September 2008, the Plaintiff claims:

(i) Damages for loss and damage allegedly sustained by him by reason of the alleged breach of contract of the Trust's servants and agents.

(ii) A declaration that the Trust is obliged to permit the Plaintiff to be legally represented at a forthcoming disciplinary hearing (scheduled to commence on 10th November 2008).

(iii) An Order that the Trust be restrained from:

(a) adopting a disciplinary procedure which does not allow the Plaintiff to be legally represented; alternatively

(b) adopting a disciplinary procedure which fails to comply with the principles of natural justice and fairness;

(c) adopting a disciplinary procedure which is in breach of the Plaintiff's Article 6 right to a fair hearing.

The context in which the forthcoming disciplinary hearing is scheduled to proceed arises out of the Plaintiff's employment by the Trust and its predecessor as a consultant cardiac surgeon since 4th May 2004 and certain charges of misconduct which have been preferred against the Plaintiff by his employer. The charges entail allegations relating to the making, alteration and substitution of operation notes on two occasions.

Contract

[3] The main complaint lying at the heart of these proceedings relates to the Trust's disinclination to permit the Plaintiff to be legally represented at an impending disciplinary hearing by a qualified practicing lawyer of his choice. The Plaintiff also advances certain discrete complaints about the fairness of various aspects of the disciplinary process. The background to these grievances will appear more fully below. At this juncture, I would highlight the causes of action invoked by the Plaintiff. Primarily, he sues in contract. Paragraphs 8 and 9 of the Statement of Claim make the case that the Plaintiff has a contract with the Trust, containing specified express and implied terms. In paragraph 36, it is averred that the Trust is in breach, or anticipatory breach, of the contract. The main breach of contract alleged is the Trust's refusal to permit the Plaintiff to be represented by a lawyer at the forthcoming disciplinary hearing. A further alleged breach of contract is the Trust's asserted failures "*to give the Plaintiff details of the witnesses to be called to give evidence despite repeated requests to do so*" and "*to properly identify the allegations which the Plaintiff faces by making an oblique reference to the Coroner's investigation*". In a Statement of Claim noteworthy for its extensive and detailed pleading, the allegations of breach of contract are couched in strikingly compact terms.

Article 6 of the Convention

[4] Secondly, the Statement of Claim promotes the case that there will be an infringement of the Plaintiff's rights under Article 6 of the Convention. This case is made in paragraphs 35 and 37, encapsulated in the following pleading:

"*37. In proceeding with the disciplinary hearing as proposed, the Defendant will be acting in breach of the Plaintiff's Article 6 right to a fair hearing*".

In the Statement of Claim, no appreciable difference between the core breaches of contract asserted by the Plaintiff and the suggested infringements of his rights under Article 6 is detectable. This is clear from the particulars of the alleged breach of Article 6 which, following an averment that dismissal of the Plaintiff from his post would have catastrophic implications for him, recites:

"*It is precisely such consequences which call for the employee to be fully and properly informed of the case he has to meet, to know precisely what the allegations are, to know who the witnesses are that are to testify in support of the charges and to be able to properly test their evidence*".

Notably, the Plaintiff's complaint regarding legal representation does not feature in these particulars. Furthermore, there is no dispute between the parties that the Plaintiff enjoys a common law right to a fair hearing in the disciplinary process. This right features in the second of the injunctions pursued by the Plaintiff.

[5] At the outset of the hearing (on 15 October 2008), two particular questions were raised by the court. The first was whether the disciplinary process will entail the determination of any criminal charge against the Plaintiff or any civil right or obligation of the Plaintiff. Decisions in cases such as ***Albert and Le Compte –v- Belgium*** [1983] 5 EHRR 553 and ***Le Compte and Others –v- Belgium*** [1982] 4 EHRR 1 seemed potentially relevant. Notably, the Statement of Claim does not plead this important issue with any clarity. The second question was whether, if the disciplinary process *does* entail the determination of any civil right or obligation of the Plaintiff, Article 6 confers on him any right greater than or different from his common law right to a fair hearing. When the trial resumed (on 24th October 2008) Mr. Boyle (representing the Plaintiff) informed the court that he was not pursuing any freestanding case under Article 6. As a result, neither party addressed argument to the court on the impact of Strasbourg decisions such as those noted above.

[6] It seems to me that, in the particular circumstances of this case, the concession with regard to Article 6 was well made, for the prosaic reason that in the Statement of Claim, the asserted breaches of Article 6 (quoted above) do not differ in any material respect from the alleged breaches of contract and the alleged infringements of the Plaintiff's common law right to a fair hearing. It might have been otherwise, of course, if the Plaintiff were making the case that, in his particular circumstances, Article 6 confers on him some right or rights greater than or different from those which he asserts in contract and at common law. However, the Plaintiff does not do so.

Contract and Common Law Right

[7] Accordingly, the spotlight falls on two of the three causes of action initially invoked by the Plaintiff. The first is his case in contract against the Trust and the second is his reliance on a common law right to a fair hearing.

II INTERLOCUTORY MOTION

[8] By Notice of Motion dated 29th September 2008, which coincided with the issue of the Writ of Summons, the Plaintiff applied for an interlocutory injunction pursuant to Section 91(1)(b) of the Judicature (Northern Ireland) Act 1978 and Order 29, Rule 1 of the Rules of the Supreme Court restraining the Defendant from adopting a disciplinary procedure:

(a) Which does not permit the Plaintiff to be legally represented;

(b) Which fails to comply with the principles of natural justice and fairness; and

(c) Which is in breach of the Plaintiff's right to a fair hearing under Article 6.

While the central focus of these proceedings is the Plaintiff's complaint in relation to (a), certain concerns in respect of (b) also were ventilated before the court. In this respect, I would observe that the court is *not* invited to make any specific ruling, by the grant of injunctive relief, on discrete issues relating to the presentation, reception or consideration of evidence at the disciplinary hearing or, indeed, any of the other criticisms canvassed on the Plaintiff's behalf under the broad banner of unfair hearing. This is clear from the terms of paragraph (ii) of the Notice of Motion, which seeks an order that:

"*The Defendant be restrained from adopting a disciplinary procedure in order to consider the allegations contained in the Notice of Hearing dated 20th August 2008 which fails to comply with the principles of natural justice and fairness*".

The generality of this formulation is in marked distinction to the other form of injunctive relief sought by the Plaintiff viz. an order that:

"*The Defendant be restrained from adopting a disciplinary procedure … which does not allow the Plaintiff to be legally represented*".

The third form of injunctive relief sought was an order similarly restraining the Trust, relying on an actual or prospective infringement of the Plaintiff's rights under Article 6: as appears from paragraphs [5] and [6] above, this is now moot.

[9] The disciplinary hearing was scheduled to commence on 10th November 2008. If the extensive hearing which I conducted, on 14th and 24th October 2008, were properly to be treated as an application for an interim injunction only, the question for the court would be whether the Plaintiff has raised a serious issue to be tried, by making out a good arguable case that the Trust is, or will be, acting in breach of contract and/or in breach of the Plaintiff's common law right to a fair hearing; and, if so, whether the balance of convenience favours the making of an injunction restraining the Trust from thus acting. These are the familiar ***American Cyanamid v. Ethicon*** [1975] AC 396 principles.

[10] On the first day of the hearing before me, (14th October 2008), a substantial quantity of evidence, consisting of affidavits and documentary materials emanating from both parties was in existence and was duly considered. When the hearing resumed (on 24th October 2008), a further voluminous quantity of additional documentary evidence had been generated and this, too, was considered by the court. These further materials included, in particular, the Trust's amended "Summary of Case"; a list of witnesses; the Trust's amended bundle of documents for the disciplinary hearing; witness statements; and inter-partes correspondence touching on the Plaintiff's representations about a variety of seemingly contentious issues.

Having reflected on the nature and quantity of the evidence ultimately assembled before the court, together with the amount of court time and resources expended in hearing this matter, and having regard to the relief claimed in the Writ and Statement of Claim (on the one hand) and the interim injunctive relief pursued (on the other), a question arose as to whether the hearing conducted before the court should be treated as the trial proper.

[11] The injunctive relief sought by the Plaintiff's Notice of Motion duplicates precisely the final injunctive relief sought in the Writ and the Statement of Claim. While it is correct that the Writ and Statement of Claim also seek a declaration, the terms in which the declaration is formulated add nothing to the first of the injunctions sought, both interim and final. This leaves outstanding the Plaintiff's claim for damages. In these circumstances, the court invited argument on whether the hearings conducted to date should properly be treated as the trial of the substantive action. Unsurprisingly, the Trust responded affirmatively. On behalf of the Plaintiff, three submissions were advanced:

(a) There was "… *a distinct possibility that evidence may need to be called at the trial of this matter to address relevant issues, for example, from the British Medical Association …*".

(b) Following the disciplinary hearing, further argument might be required on "… *whether there has been a breach of the Plaintiff's rights under Article 6 …*".

(c) Finally, there are still significant contentious issues between the parties, notwithstanding the developments noted in paragraph [10] above.

[12] I preface my treatment of these there submissions with two observations. The first is that all of the forms of injunctive relief sought by the Plaintiff, both interim and final, seek to restrain the Trust from certain forms of conduct *in advance of the forthcoming disciplinary hearing*. Each of these injunctions will become meaningless and moot following completion of the disciplinary hearing. Secondly, the Plaintiff has at no time sought an expedited trial. Accordingly, as the Plaintiff's case is presently framed, the only remedies claimed which could conceivably survive the completion of the forthcoming disciplinary hearing are a declaration and damages. As already observed, the declaration claimed is identical to the first of the injunctions claimed.

[13] With regard to the three discrete submissions advanced by the Plaintiff:

(a) I consider the first to constitute a bare and unparticularised assertion, which I dismiss as without merit. Moreover, it fails to address the considerations highlighted in paragraph [12] above.

(b) I have dealt fully with the Article 6 issue above: In the circumstances of this case, *as pleaded*, it adds nothing to the Plaintiff's case in contract and at common law.

(c) The "*significant number of issues*" allegedly still in contention between the parties do not, in my view, entitle the Plaintiff to any relief, interim or final, as appears from the further terms of this judgment. Furthermore, these issues now belong to a future framework of which the court is not seized and it is not the function of the court to allow these proceedings to remain in existence with a view to policing possible future events which may or may not occur. Finally, as appears from what follows in this judgment, I have concluded that the

Plaintiff enjoys a contractual right to be accompanied by a legally qualified person of his choosing at the forthcoming hearing.

In the circumstances and for the reasons outlined above, and taking into account the over-riding objective enshrined in RSC Order 1, Rule 1A – in particular paragraph (2)(b), (c), (d) and (e) – I have concluded that the hearings already conducted should be treated as the trial of the action proper, subject to permitting the Plaintiff to have liberty to apply, within a specified period, to submit further and fresh evidence in support of his claim for damages, in the event that there should be any real and sustainable basis for doing so.

[14] In the light of my ruling to treat the proceedings before the court as the trial of the action proper, the determination of this matter will not be governed by the ***American Cyanimid*** principles. Rather, the question for the court is whether, applying the civil standard of the balance of probabilities, the Plaintiff has discharged the onus of establishing that he is entitled to either of the injunctions claimed which, in the light of the disappearance of the claim based on Article 6, are those set out in paragraph [2](iii) (a) and (b) above; or, alternatively, a declaration in the terms claimed viz. a declaration that the Trust is obliged to permit the Plaintiff to be legally represented at the disciplinary hearing. There is no claim for damages by the Plaintiff which the court could determine at this stage.

III THE EVIDENCE: A SUMMARY

[15] The material dates and events are detailed in a helpful chronology supplied to me by counsel for the Plaintiff. They are also documented in the substantial bundles of documentary materials generated as the hearing progressed. It is unnecessary for me to rehearse the evidence exhaustively. I shall, rather, endeavour to highlight the most salient facts forming the background to this application.

The Plaintiff's Contract

[16] The Plaintiff's contract of employment with the Trust is constituted by a "Statement of Main Terms and Conditions of Employment for Medical Consultants". This records that the Plaintiff's employment with the Trust as a consultant cardiac surgeon began on 4th May 2004. Clause 4 specifies a mutual obligation "… *that you and we work in a spirit of mutual trust and confidence*". Clause 16 requires the Plaintiff to comply with the Trust's policies and procedures. Clause 18, under the label of "**Disciplinary Matters**", provides:

"*Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures. However, should we consider that your conduct or behaviour or that your professional competence have been called into question, we will resolve the matter through our disciplinary or capability procedures, subject to the appeal arrangements set out in those procedures*".

It is evident that the Trust's "*disciplinary or capability procedures*" are not incorporated in this document. Rather, they have a separate existence.

The DHSSPS Circular, the Framework Code and the Trust's Code

[17] Next, it is appropriate to consider a DHSSPS Circular, dated 30th November 2005 ("*the Circular*"). This Circular was made by and emanated from the Department of Health,

Social Services and Public Safety ("*the Department*"), which is the parent body. The first attachment to the Circular is an instrument entitled "Directions on Disciplinary Procedures 2005". I shall examine the status and effect of this instrument below. The Circular also attaches a document, described as "*A new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees*", bearing the title "*Maintaining High Professional Standards in the Modern HPSS*" and dated November 2005 (hereinafter described as "*The Framework Code*"). It further records that this new Code has been agreed with BMA and BDA and that it supersedes specified pre-existing instruments of guidance. The Circular also contains the following statements:

"*The new framework is effective from 1st December 2005 …*

HSS Trusts, HSS Boards and Special Agencies are required to notify the Department of the action they have taken to comply with the framework by 31st January 2006".

[18] Paragraph 2 of the Framework Code provides:

"*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*".

By paragraph 11:

"*All HSS bodies must have procedures for handling concerns about an individual's performance. These procedures* ***must*** *reflect the framework in this document …*".

[My emphasis].

The structure of what follows establishes a dichotomy of the "*informal approach*" and the "*formal approach*". The latter is addressed in paragraphs 28-30. The Framework Code also establishes a further dichotomy of (a) conduct disciplinary proceedings and (b) clinical performance disciplinary proceedings. The proceedings with which this litigation is concerned are of the former type.

[19] Paragraph 28 of the Framework Code contemplates that where the formal approach is adopted, this could lead to "*conduct or clinical performance proceedings*". This has a series of procedural consequences. By paragraph 29, all concerns are to be investigated quickly and properly, with a clear audit route. Paragraph 30 continues:

"*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*".

Finally, Section III of the Framework Code, bearing the title "Guidance on Conduct Hearings and Disciplinary Procedures", provides, in paragraph 1:

"*This section applies when the outcome of an investigation under Section 1 shows that there is a case of misconduct that must be put to a conduct panel …*

Misconduct covers both personal and professional misconduct …

All misconduct issues should be dealt with under the employer's procedures covering other staff where conduct is in question".

[20] The next document to be considered is entitled "Belfast Health and Social Care Trust – Disciplinary Procedure" (which I shall describe as "*the Trust's Code*"). This contains, in its "Introduction", the following passage:

"*This Procedure applies to all Trust staff. It should be noted that in relation to medical and dental staff, issues of general/professional misconduct are dealt with under this Procedure. Further relevant Procedures are contained in Circular HSS (TC8) 6/2005* ."

Thus the Trust's Code makes direct reference to the departmental Circular, discussed in paragraph [17] above. Further, it is evident from this passage that the Trust's Code postdates the departmental Circular and this is confirmed by the signatures of the Regional Staff and Trust representatives, which are dated 28th August and 3rd September 2007 respectively.

[21] In paragraph 2 of the Trust's Code, under the banner "Guidance and Definitions", there is the following entry:

" '***Employee Representative***' *is any employee of the Trust who is an accredited representative of a trade union, professional organisation or staff organisation or a full time official of any of the above organisations or a fellow Trust employee.* ***Legal representation will not be permitted at any stage of this Disciplinary Procedure***".

[Emphasis added].

Thus a purported prohibition on legal representation finds expression in a definition, but not elsewhere. Amongst the provisions governing the conduct of investigations is paragraph 6.2(a), which provides, *inter alia*:

"*The Investigating Officer should meet with the employee who may be accompanied and/or represented by an employee representative*".

[22] Paragraph 6.3 of the Trust's Code, under the title "Hearing", contains an assortment of provisions governing the constitution and activities of a body described as the "Disciplinary Panel". I would highlight the following aspects in particular:

"*(a) If it is considered that there is a case to be answered, the employee should be called to attend a disciplinary hearing before the appropriate Disciplinary Panel …*

The employee should be informed in writing of the allegation and the right to be represented …

(e) The employee shall normally be present during the hearing of all the evidence put before the Panel; however, the employee may choose not to attend the hearing. It should be made clear that the hearing will proceed in his or her absence. Any submission by the employee in writing or by his or her representative will be considered …

(g) At the hearing, the case against the employee and the evidence should be detailed by the presenting officer and the employee should set out his/her case and answer the allegations.

(h) Witnesses may be called by either party and can be questioned by the other party and/or by the Disciplinary Panel. The presenting officer and the employee/ representative will have the opportunity to make a final submission to the Disciplinary Panel at the end of the hearing with the presenting officer going first. The Disciplinary Panel has the right to recall any witnesses but both sides and their representatives have the right to be present".

Finally, paragraph 6.4 ("Disciplinary Decision") provides, in material part:

"*(a) The Disciplinary Panel will review all the evidence presented before taking its decision. The Disciplinary Panel will determine on a balance of probability whether the allegations were or were not proven.*"

Many of the passages from the Trust's Code quoted above highlight the importance which is attributed to the employee's right to representation throughout the entirety of the disciplinary process. The question which the court must resolve concerns the precise content and scope of this contractual right in relation to a disciplinary hearing.

The Disciplinary Charges

[23] On 15th April 2008, the following disciplinary charges were notified in writing to the Plaintiff:

"*1. Failed to take contemporaneous notes of the operations you performed on the patient MF.*

2. Changed the notes for both operations, on 10/4/05 and 30/5/06 of patient MF that were filled in the patient's chart in August 2006.

3. Failed to indicate in the patient's chart that any amendments had been made or record those changes in the patient (MF) records.

4. Removed versions of notes from the patient's chart (MF) and substituted them with other notes without recording in the patient's chart that any alterations or substitutions had been made".

(In passing, it would appear that the date of the first operation, specified in the second of the charges, should be *10/04/06*). In short, in the disciplinary process the Plaintiff is charged with a series of irregularities, undoubtedly serious in nature, relating to the making, maintenance, alteration and substitution of records pertaining to the operative treatment of a particular patient on two separate occasions.

[24] At the time when he was notified of the disciplinary charges, the Plaintiff was served with a bundle of documents described as "*presentation papers*", intended for consideration by the Disciplinary Panel. On the first day of the hearing of this interlocutory application (14th October 2008), it became apparent that the parties' legal representatives had not yet exhausted attempts to resolve the differences between them concerning the composition of this bundle. These attempts continued (I was informed) during the period which elapsed before the second

day of hearing (24th October 2008). I considered this a matter of no little significance, given that in his pursuit of interlocutory injunctive relief, the Plaintiff was relying substantially on the inclusion of what he claimed were prejudicial, or otherwise improper, materials in both the bundle and its accompanying "Case Summary". I consider that this latter document, properly analysed, contains in essence the particulars, or outworkings, of the charges specified in the communication dated 15th April 2008, which are rather sparse in particularity.

[25] On the second day of trial, the further evidence and submissions presented to the court confirmed that some of the differences between the parties relating to the above matters had been resolved. Others endured. I shall give some further consideration to this subject below. At this juncture, I would merely observe that the disciplinary charges remain unchanged.

[26] As regards the Trust's case against the Plaintiff in the disciplinary process (as understood by the court), the pattern of alleged irregularities concerning the record keeping in respect of both operations would appear to be broadly similar. As regards each operation, the bundle contains, *inter alia*, more than one version of each operation note. There are evident differences between these versions. Thus, *for example*, there is an operation note pertaining to the first operation apparently signed only by Mr. Pramond Bonde, a surgical registrar, described in the record as the Plaintiff's "*assistant*". However, there is a second version of this note, which, evidently, purports to represent that the operation was performed by the Plaintiff. Moreover, there is a third version of this note whose contents, relating to matters such as "Findings" and "Closure", differ from the first two versions. This provides a flavour of the issues which will be explored, and determined, by the Disciplinary Panel.

The Correspondence

[27] The evidence includes a detailed letter dated 14th July 2008 from the Plaintiff's solicitors to the Trust's Medical Director, Dr. Stevens, which makes a series of representations about certain aspects of the disciplinary process, in particular the contents of the bundle of documentary evidence and the formulation of the "C*ase Summary*". This letter contains an extensive menu of requests, including the provision of a list of witnesses to be called at the hearing and the production of witness statements. The letter further makes the case that the Plaintiff should be permitted to have legal representation at the disciplinary hearing, in the following terms:

"*Clearly, in this case, given the nature of the allegations, the credibility of the witnesses is likely to be of crucial importance. We would submit, therefore, that presentation of MA's position and detailed cross-examination of the witnesses at the disciplinary hearing ought (in accordance with MA's Article 6 rights)* [to] *be performed by a skilled advocate. We are very keen to avoid a situation in which MA is cross-examining colleagues and management staff as this could cause acute embarrassment to both parties …*

We consider there is a real risk of unfairness to MA, were he to be reluctant to pursue a line of questioning against one of his colleagues whom he will have to return to work with after the disciplinary hearing. Similarly, the witnesses called by the Trust may be reluctant to speak frankly at the disciplinary hearing if MA is cross-examining them. There will also clearly be a major potential impact on MA's career as a cardiac surgeon in the United Kingdom should an adverse finding be reached …

Finally, we consider that having a skilled advocate represent MA is likely to result in the disciplinary hearing being dealt with more fairly, efficiently and cost-effectively for all concerned".

[28] This was not the first letter written on the Plaintiff's behalf by his solicitors. Rather, it was preceded by a letter dated 16th June 2008, also addressed to Dr. Stevens. While this letter also contained a contention that the Plaintiff should have "*full and proper legal representation*" at the disciplinary hearing, it is noteworthy that it describes the allegations against the Plaintiff in the "S*ummary of Case*" as "*very limited and specific*". This characterisation of the allegations was the impetus for the contention that most of the documents in the Trust's bundle for hearing were "*irrelevant and prejudicial*". In response to this letter, Dr. Stevens, *inter alia*, referred to the definition of "*employee representative*" in paragraph 2 of the Trust's Code (see paragraph [21], *supra*).

[29] By letter dated 30th July 2008 to Dr. Barclay, Deputy Medical Director of the Medical Protection Society, Dr Stevens, with reference to the discrete issue of legal representation, stated:

"*In relation to legal representation, the Trust does not consider that legal representation is either appropriate or necessary in this case. The case law referred to has been considered, but the circumstances of this case are not considered to be comparable to the complex allegations which were the subject of the cases referred to. As Carson McDowell put it in their letter, the allegations in this case are, by contrast, 'very limited and specific'. The Trust does not accept that there are any special circumstances in this case which give rise to a right to legal representation over and above the right to representation set out in the Trust's Disciplinary Procedure …*

The Trust has already conceded that, in the circumstances of this case, and in view of Dr. Barclay's extensive involvement to date, MA can continue to be represented by Dr. Barclay of MPS whom we understand to be an experienced representative."

The twofold suggestion that Dr. Barclay (a) has been extensively involved in the affair to date and (b) is an experienced representative is unchallenged in the evidence before the court. Moreover, it is common case that Dr. Barclay holds a law degree.

[30] With reference to the "C*ase Summary*", Dr. Stevens stated, in his letter dated 30th July 2008:

"*It is normal practice for the Presenting Officer to provide his views on the evidence and the conclusions he would invite the Panel to draw from the evidence. These views form part of the management case. No doubt, these views and conclusions will be countered by MA and his representative and it is clearly for the Panel to reach its own conclusions on the basis of all the evidence and representations*".

The letter further confirmed that all witnesses would be vulnerable to questioning by the Panel members, the Presenting Officer and the Plaintiff's representative. Thus there would be no need for the Plaintiff to question any witness, given Dr. Barclay's role, unless the Plaintiff should choose to do so.

[31] The inter-partes correspondence continued immediately prior to and during the trial of this matter. On 10th October 2008, the Plaintiff's solicitors were supplied with a list of the witnesses whom the Presenting Officer intends to call at the impending hearing. Simultaneously, some modifications of certain documentary materials were confirmed. Moreover, the Trust's solicitor reiterated an earlier statement that none of the Disciplinary Panel Members will consider the bundle of documentary evidence in advance of the hearing. The first day of trial then intervened (on 14th October 2008). Further letters and communications between the parties' legal representatives ensued. During this period witness statements, an amended bundle for hearing and certain other documentary materials were served on the Plaintiff's solicitors. This process resulted in an ever diminishing number of matters in contention between the parties. The persisting contentious issues, from the Plaintiff's perspective, are set out in a letter dated 22nd October 2008 written by his solicitors. In summary, the Plaintiff seeks disclosure of certain documents; he challenges the amended bundle for hearing in certain respects; and he contends that certain passages in the witness statements should be deleted.

[32] It was confirmed to the court by the Plaintiff's counsel that certain of the requests, representations and complaints enshrined in this letter are no longer live. Some of those which remain extant relate to matters which might be considered relatively minor. For example, there is a request for clarification of whether "cleaner" copies of certain operation notes have previously been furnished. To like effect are a query about a blank page in the bundle for hearing and a request concerning who attended a particular meeting. Properly analysed, the Plaintiff's persisting complaints about the bundle for hearing relate in substance to certain references to the issue of reporting the death in question to the Coroner. The other outstanding representations and requests do not bear directly on the question of the composition of the bundle in its current amended form, with the exception of a discrete issue relating to record maintenance and storage policies which, by the second day of trial, remained an evolving, unresolved issue between the parties. The last item of correspondence in the evidence before the court is a letter dated 23rd October 2008 from the Trust's solicitor to the Plaintiff's solicitors. The contents of this letter suggested that the process of attempting to narrow the issues between the parties was not necessarily exhausted.

The Affidavit Evidence

[33] In resisting the Plaintiff's case, three affidavits were filed on behalf of the Trust. For present purposes, the most significant of these is that of Dr. Hannon, the Trust's Associate Medical Director who will have the role of presenting officer at the forthcoming disciplinary hearing. Dr. Hannon's affidavit deals with two salient issues in some depth. The first relates to the Framework Code. Dr. Hannon contends that, under the aegis of the Framework Code, legal representation "… *is only available if the charges against the Plaintiff relate to his clinical competence and performance*".

[34] The second noteworthy feature of Dr. Hannon's affidavit is that it highlights the extensive involvement of Dr. Barclay (of the MPS) from an early stage of events, in 2006. Dr. Hannon avers that Dr. Barclay "… *has detailed knowledge of events from June 2006 until the present time* …". Dr. Hannon rebuts the suggestion that the charges against the Plaintiff give rise to unduly complex issues. Thirdly and finally, Dr. Hannon's averments include the following:

"*5(d) … In the course of the investigation conducted by Professor Nixon and Mr. Brown, the Plaintiff was interviewed and acknowledged that he had altered some of those operation notes, had removed some of the original operation notes and replaced them with later written notes and failed to indicate anywhere that notes had been altered, removed and replaced. The Plaintiff provided a fulsome explanation for his acts but it is the Trust's view that those acts constituted professional misconduct and gave rise to the present charges*".

I would observe that the affidavit evidence on behalf of the Plaintiff does not challenge these averments.

[35] The averments in Dr. Hannon's affidavit contrast with certain averments in the affidavit sworn by the Plaintiff's solicitor grounding this application:

"*[24] It should be apparent … that if the Plaintiff does not have the benefit of a trained advocate, he faces the daunting prospect of preparing for and cross-examining a number of experts and a number of high ranking members of the Trust staff …*

[25] *Furthermore, the issues to be addressed during the hearing will include, but will not be limited to, the Trust's procedures for completion of medical records, the nature of the surgery performed on MF, the interpretation of documents and the basis and evidence upon which inferences have been drawn by a number of the witnesses above. Then, having cross-examined some or all of the above, the Plaintiff faces the prospect of trying to give his own evidence in a clear and methodical fashion …* [and] *faces the prospect of going back to work either directly with or under the auspices of people he has had to ask some very searching questions of …*".

This affidavit also highlights the potentially serious consequences for the Plaintiff, in the event of an outcome adverse to him. The affidavit does not address the availability of Dr Barclay's services to the Plaintiff or how this might affect the concerns ventilated in the averments quoted above.

[36] The Trust's affidavits were all sworn on 13th October 2008. By the date when the hearing of this matter was finalised, 24th October 2008, neither the Plaintiff nor anyone on his behalf had rejoined to these affidavits, despite the opportunity which existed to do so. Nor was there any direct challenge during the hearing to of Dr. Hannon's averments set out in paragraph [] above.

IV THE PLAINTIFF'S CASE

[37] The breadth of the Plaintiff's case, as portrayed in the Statement of Claim and his counsel's skeleton argument, was refined somewhat in the course of oral submissions. As appears from paragraphs [24] – [32] above, there were significant developments following the initiation of these proceedings, with a corresponding diminution in the matters in contention between the parties.

[38] In summary, it was submitted on behalf of the Plaintiff that there are several serious questions to be tried in the action, specifically those relating to whether the Trust had breached the contractual term requiring mutual trust and confidence; had breached its contractual obligation to give effect to the Framework Code and, specifically, the provision concerning legal representation; and was proposing to act in breach of contract by conducting

a disciplinary hearing in contravention of the Plaintiff's common law right to a fair hearing. It was contended that the Plaintiff enjoys a contractual right to legal representation at the forthcoming hearing. The Plaintiff's alternative contention was that, as a minimum, the Trust has a discretion to permit this facility. This alternative contention is, presumably, founded on the Plaintiff's common law right to a fair hearing. The Plaintiff's argument rested heavily on the contention that he will have to grapple with difficult issues concerning the relevance and admissibility of evidence, a submission which Mr. Boyle developed at some length by reference to various passages in the bundle of documentary evidence. To similar effect was the submission relating to hearsay evidence and the burdens which, it was said, this will impose on the Plaintiff.

V THE DEFENDANT'S CASE

[39] On behalf of the Trust, Mr. O'Reilly's main submission was that the case against the Plaintiff in the forum of the disciplinary proceedings is uncomplicated. He developed this submission in the following way:

(a) Mr. Gladstone is the only medical colleague of the Plaintiff who will be testifying at the hearing and his testimony will relate only to the circumstances in which he secured copies of the notes in question.

(b) Three of the other witnesses – Professor Nixon, Mr. Brown and Dr. Stevens – all had the role of investigator and will, in consequence, be witnesses of fact, in common with Mr. Gladstone.

(c) The only witness who will give expert opinion evidence is Dr. Venn, whose testimony will bear on the issues relating to the propriety of the Plaintiff's conduct regarding the operation notes in question and the appropriate standards to be followed.

Mr. O'Reilly's submissions also highlighted that the presenting officer, Dr. Hannon, is a consultant vascular surgeon with no legal qualifications; that ample legal advice will be available to the Plaintiff in advance of the hearing; that the Plaintiff will have the assistance, advice and representation of Dr. Barclay before and throughout the hearing; that the Plaintiff has already been interviewed about the subject matter of the disciplinary charges and has had sufficient time to prepare for the hearing; and that the issues to be explored and determined at the hearing must be evaluated in the light of Dr. Hannon's averments about the acknowledgements which the Plaintiff has already made with regard to the operation notes (paragraph [34] above). Finally, Mr. O'Reilly was disposed to accept that the provisions of the Trust's Code relating to representation at disciplinary hearings are not harmonious with the Framework Code. He submitted, however, that in the particular circumstances of this case this disharmony had been remedied by the Trust's express acknowledgement that the Plaintiff can be represented by Dr. Barclay at the forthcoming hearing.

VI CONCLUSIONS: CONTRACT

[40] The material terms of the Plaintiff's written contract of employment, together with the relevant provisions of the departmental Circular, the departmental Framework Code and the Trust's Code are set out in paragraphs [17] – [22] above. These materials are especially germane to the *first* of the injunctions pursued by the Plaintiff viz. an injunction restraining the disciplinary hearing from proceeding unless the Plaintiff is permitted "*to be legally*

represented", together with the corresponding declaration sought. Having regard to the presentation of the Plaintiff's case to the court, this emerged, by a distance, as the main issue to be determined.

[41] The first contention advanced on behalf of the Plaintiff, in Mr. Boyle's skeleton argument, is that the Trust has, in various respects, acted in breach of Clause 4 of the Plaintiff's written contract of employment, which imposes a bilateral obligation of mutual trust and confidence on employer and employee. This contention is duly particularised in the Plaintiff's skeleton argument, but not in the Statement of Claim. In this respect, I refer particularly to the breaches of contract pleaded in paragraph 36. Moreover, this discrete contention and its outworkings are not easily related to the two forms of injunction sought in paragraph 41(a) and (b). Accordingly, I consider that this does not properly form part of the Plaintiff's case, as pleaded. In any event, insofar as the court is properly seised of this contention, I find that it has no substance. Most of its particulars relate to purely historical events which have no enduring significance. While two of its particulars relate to the "Case Summary" and the composition of the bundle for hearing, I find that neither of these discrete complaints constitutes a breach of clause 4 of the contract by the Trust. Where, as here, an employee is charged with serious misconduct, there can be no objection to the Presenting Officer, representing the views of management, adopting the stance that the charges are well founded and will be proved to the satisfaction of the Disciplinary Panel. I find that this does not breach the Trust's obligation to work with the Plaintiff in a spirit of mutual trust and confidence.

[42] The second contention advanced on behalf of the Plaintiff is that he has a contractual entitlement to be legally represented, by a qualified practicing lawyer of his choosing, at the forthcoming disciplinary hearing, with the result that any denial by the Trust of such entitlement gives rise to a breach of contract. There is something incongruous about this aspect of the Plaintiff's case, as it rests on the premise that the Trust's Code – which, the parties are agreed, forms part of the Plaintiff's contract of employment – does *not* contain a provision to this effect: this was the case advanced in argument before the court and it is unambiguously made in paragraph 11 of the Plaintiff's skeleton argument:

"*The Defendant's disciplinary policy, in breach of the requirement to comply, does not reflect the Framework. It is far more restrictive …*

It does not allow for a defence organisation representative or a work or professional colleague. It does not allow for anyone legally qualified".

Notably, the Plaintiff's Statement of Claim does *not* make the case that the Trust is in breach of contract, or is otherwise acting unlawfully, by failing to give adequate effect to the departmental Circular and paragraph 30 of the departmental Framework Code in particular. This is reflected in the breaches of contract particularised (in paragraph 36) and the relief sought (in paragraphs 40 and 41). Moreover, the Plaintiff does not seek either a declaration that the Trust is acting unlawfully by its alleged failure to expressly incorporate paragraph 30 of the Framework Code in its own code or an injunction requiring it to do so.

[43] There is an evident dislocation between the Plaintiff's contention that his contract of employment entitles him to legal representation at the disciplinary hearing (on the one hand) and his supporting argument that the contract does not contain a term to this effect (on the other). In the circumstances, I consider that it is incumbent on the court to both ascertain and

construe the relevant contractual terms. In adopting this approach, I note that in ***Arbuthnot Fund Managers –v- Rawlings*** [2003] EWCA. Civ 518, a case concerning the grant of interlocutory injunctions in an employment dispute with elements of post-termination contractual restraints, Chadwick LJ stated:

"*[20] The first task of the court – faced with the contention that post-termination restraints on an employee's ability to engage in future business activity are not enforceable – is to construe the contract under which those restraints are said to be imposed.* ***That, as it seems to me, is a task which the court ought to carry out on an application for interim relief (if there is one) if it can properly do so.*** *Unless the court is satisfied that there are disputed facts which bear on the construction of the relevant contractual terms, and that those facts cannot be resolved without a trial, the court at the interlocutory stage is as well able to construe the relevant contractual terms as a court will be at a trial. There is no need to put off until trial determination of the question – what do the contractual terms mean?*"

[My emphasis].

Accordingly, my approach would have been precisely the same irrespective of whether I were to treat this matter as an application for interim injunctive relief or the trial of the action in which the same relief is claimed in final terms.

[44] By Clause 18 of the written contract, disciplinary matters are governed by the Trust's "*disciplinary or capability procedures*", which are not specified and are, therefore, to be found elsewhere, if they exist. If such procedures do exist, I hold that they are, as a matter of law, to be incorporated by reference, thereby giving rise to contractual rights and obligations. In this instance, the "*disciplinary or capability procedures*" are found in the Trust's Code, as outlined in paragraphs [20] - [22] above. It is beyond dispute that this Code does not contain a provision which mirrors paragraph 30 of the departmental Framework Code (cf. paragraph [19] above). Rather, the Trust's Code contains a provision which is positively antithetical to paragraph 30 ["*Legal representation will not be permitted at any stage of this disciplinary procedure*"]. At the hearing before me, Mr. O'Reilly acknowledged, appropriately, that the Trust's Code should not be framed in this way, as it does not properly reflect the departmental Framework Code. In the circumstances, the question which, in my view, must be confronted and determined is whether the departmental Framework Code has been, as a matter of law, incorporated into the Plaintiff's contract of employment.

[45] Underlying this last-mentioned concession was an acknowledgement that the Trust is bound to give effect to the departmental Circular. For reasons which will become clear, I consider that the "Directions" to which the departmental Circular refers and which append the Framework Code provide the key to the correct resolution of the primary issue to be determined by the court. These “Directions” fall to be considered in their statutory context.

[46] Within the elaborate statutory arrangements regulating the provision of health and social services in Northern Ireland, Article 17(1) of the Health and Social Services (Northern Ireland) Order 1972 provides:

"*(1) The Health and Social Services Boards shall –*

(a) exercise on behalf of the [Department] *such functions … with respect to the administration of such health and personal social services as the* [Department] *may direct …*

and shall do so in accordance with Regulations and directions".

Thus the Department is empowered to issue *directions* to Boards. Trusts are a more recent creation of statute. In paragraph 6 of Part II of Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991 ("*the 1991 Order*") it is provided:

"*(1) An HSS Trust shall carry out effectively, efficiently and economically the functions for the time being conferred on it by an order under Article 10(1) and by the provisions of this Schedule.*

(2) ***An HSS Trust shall comply with any directions given to it by the Department about the exercise of the Trust's functions.***"

[Emphasis added].

Thus Trusts have a statutory obligation to comply with directions addressed to them by the Department. This is a reflection of the hierarchical statutory arrangements for the provision of health and social services in Northern Ireland (which, in this sense, are broadly comparable with those in England: see ***Halsbury's Laws of England*** (5th Edition), Volume 54, paragraphs 6-12).

[47] On 29th November 2005, the Department made the instrument entitled "Directions on Disciplinary Procedures 2005" (hereinafter "*the 2005 Directions*"). This instrument provides, in material part:

"*1(1) This direction is given to all HSS bodies.*

(2) This direction shall come into force on 1st December 2005 …

(4) In this direction 'HSS body' means …

(ii) A Health and Social Services Trust …

2. Each HSS body shall comply with 'Maintaining High Professional Standards in the Modern HPSS – a Framework for the Handling of Concerns about Doctors and Dentists Employed in the HPSS' – ('the Framework') as set out in the schedule and promulgated in Circular HSS(TC8) 6/2005.

3. Each HSS body shall notify the Department of the action they have taken to comply with the Framework by 31st January 2006".

I consider it necessary for the court to construe the 2005 Directions and evaluate their impact and consequences.

[48] Notably, the 2005 Directions are not prescriptive as regards *how* HSS bodies are to perform the central obligation to which they are subject viz. the obligation to comply with the departmental Framework Code. Furthermore, they do not expressly contemplate either a phased introduction of the Framework Code or a time limit for its implementation. Rather, by their terms, the 2005 Directions *shall* come into force on 1st December 2005. Paragraph 2 does *not* provide that HSS bodies shall take certain prescribed steps to comply with the

departmental Framework Code. Rather, it provides, unequivocally, that HSS bodies *shall* comply therewith. In my view, paragraph 3 of the Directions is ancillary in nature. I do not construe it as stipulating a deadline for compliance. Rather, I consider that it is to be construed as a means of encouraging immediate compliance *and* a mechanism for departmental supervision of compliance. If I am wrong in these conclusions, I consider the only alternative construction of the 2005 Directions to be that the Framework Code had to be implemented by (*inter alia*) Trusts by, at the latest, 31st January 2006. Whichever of these two constructions is correct, the legal consequence which follows in the context of the present litigation is the same.

[49] I consider that the 2005 Directions had the effect of imposing an absolute obligation of compliance with the Framework Code on all agencies to whom they were addressed. The Trust was one of these agencies and, in my view, it had no discretion of any kind in this respect. Nor did the Trust have any legal power to devise a code or procedure or other arrangement in any way non-compliant with or repugnant to any of the provisions in the departmental Framework Code. Accordingly, insofar as any of the provisions of the Trust's Code are of this character, I hold that they are *ultra vires*, unlawful and of no effect. This applies particularly to the definition of "*employee representative*" in paragraph 2 of the Trust's Code, inasmuch that this definition unambiguously forbids legal representation of the Trust employee at any stage of a disciplinary procedure. (While this definition may not be harmonious with paragraph 30 of the departmental Framework Code in certain other additional respects, none of these arises for consideration and determination in the present context).

[50] I consider that the Plaintiff's contract of employment with the Trust, the 2005 Directions and the departmental Framework Code are to be analysed in the following way:

(a) By Clause 18 of the Plaintiff's written contract of employment, the Trust's disciplinary procedures were incorporated by reference. I consider that this clause applies to such disciplinary procedures as may exist from time to time.

(b) By virtue of the statutory provisions noted above, the Department is empowered to give directions to Trusts and Trusts are obliged to comply with such directions.

(c) By a duly made instrument of subordinate legislation dated 29th November 2005 viz. the 2005 Directions, the Department directed the Trust (and others) to comply with the departmental Framework Code.

(d) From 1st December 2005 (or, at the very latest, 31st January 2006), the departmental Framework Code was incorporated into the Plaintiff's contract of employment.

(e) Paragraph 30 of the departmental Framework Code states unequivocally that the medical or dental practitioner concerned may, at any stage of a disciplinary process, be "… *accompanied to any interview or hearing by a companion* … [who] *may be legally qualified but he or she will not, however, be acting in a legal capacity*".

(f) It follows that the Plaintiff is legally entitled, as a matter of contractual right, to be accompanied by a legally qualified person of his choosing at the forthcoming disciplinary hearing.

[51] The same conclusion may be reached by a somewhat different route. By its express terms, the Trust's Code does not purport to be exhaustive. Rather, in its Introduction, it makes explicit reference to "*further relevant procedures*", as contained in the departmental Circular which, in turn, refers to and appends the Framework Code. In my view, this passage in the Trust's Code incorporates the Framework Code in its entirety. Furthermore, the provisions of the Framework Code must take precedence over any inconsistent or repugnant provisions in the Trust's Code, given the Trust's legal obligation to comply fully with the Framework Code.

[52] It was argued on behalf of the Plaintiff that paragraph 30 of the Framework Code is to be construed as conferring on the practitioner concerned a right to be accompanied to any interview or hearing by any legally qualified person of the practitioner's choosing. I reject this argument. Paragraph 30 states unambiguously:

(a) The practitioner may be accompanied by "*a companion*".

(b) Companion is defined as "*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*".

(c) The "*companion*", the text continues, "*may be legally qualified but he or she will not, however, be acting in a legal capacity*".

I hold that paragraph 30 confers on the practitioner concerned a right to be accompanied by a "*companion*", as defined, who may, at the practitioner's election, be a legally qualified person. The Plaintiff's argument was that paragraph 30 entitles him to be accompanied at the disciplinary hearing by a legally qualified person such as his counsel in the present proceedings. In my opinion, this argument is confounded by the clear language of paragraph 30, which requires no special interpretation and is devoid of ambiguity. The wording of paragraph 30 simply does not bear the construction advocated on behalf of the Plaintiff.

[53] I have held that paragraph 30 of the Framework Code is to be construed as conferring on the practitioner concerned a right to be accompanied by a companion (as defined) *of the practitioner's choosing*. The Trust has denied the Plaintiff this right in the present case. While the Trust is prepared to allow the Plaintiff to be accompanied at the hearing by Dr. Barclay of the Medical Protection Society and while Dr. Barclay holds a law degree, the case made is that he is not the legal representative of the Plaintiff's choice. I consider that paragraph 30, properly construed, does not entitle the Trust to impose on the practitioner concerned a companion of the Trust's choosing. Thus the Trust has not given due effect to paragraph 30 in the present case.

[54] I would add that the contractual right which I have held to be enjoyed by the Plaintiff is a right to be accompanied by a legally qualified person of his choice who, in the language of paragraph 30 of the Framework Code, "*… will not, however, be acting in a legal capacity*". The issues of which the court is seised in these proceedings do not include the definition of these words. They are regrettably opaque and have the potential to give rise to still further controversy between the parties. Clearly, it would be desirable that the parties endeavour to reach agreement on this matter in advance of the hearing. Of course, any such agreement would not be binding on the Disciplinary Panel which, in my view, will be the ultimate arbiter of issues of this kind.

[55] I would offer the following guidance on this discrete issue. While this will not be a clinical performance hearing (rather, a misconduct hearing), I consider that paragraphs 13 and 14 of Section IV of the Framework Code apply to both types of hearing. Paragraph 14 contains the following sentence:

"*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*".

This provision *must* be read in conjunction with paragraph 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*".

I consider that paragraphs 13 and 14 serve to illuminate the opacity highlighted above. The Plaintiff's representative will doubtless bear paragraph 13 carefully in mind at the forthcoming hearing. Simultaneously, the Disciplinary Panel will have to be mindful of the Plaintiff's common law right to a fair hearing. The provisions of both the Framework Code and the Trust's Code are to be considered, construed and applied *in the light of this common law right*. Neither of the Codes takes precedence over or in any way emasculates this right. In this respect, the Panel will undoubtedly be mindful of the seriousness of the charges and what is at stake for the Plaintiff.

[56] Finally, as regards the contractual issues, I reject the suggestion in Dr. Hannon's affidavit that the Framework Code establishes a right to legal representation only if the charges against the employee relate to clinical competence and performance. In my opinion, construing the Framework Code as a whole, this suggested interpretation is unsustainable. I refer particularly to paragraphs 1 and 2 of the "Introduction" and paragraphs 28-30 of Section 1 ("Action When a Concern First Arises"). While paragraphs 13-14 of Section IV are located under the heading "Procedures for Dealing with Issues of Clinical Performance", they do not, in my view, in any way dilute the clear import of paragraphs 28-30 of Section 1, which establish unambiguously a right to be accompanied by a companion (as defined) of one's choosing in the context of both conduct *and* clinical performance proceedings. While the drafting and layout of the Framework Code may be a little clumsy, I consider that its material provisions do not yield any other sustainable or sensible construction.

[57] My finding that the Trust has failed to give full and proper effect to paragraph 30 of the Framework Code gives rise, *prima facie*, to a basis for granting the Plaintiff relief. I shall return to this issue in paragraphs [70] – [71] below.

VII CONCLUSIONS: COMMON LAW RIGHT

[58] The Plaintiff makes the case that, by virtue of his common law right to a fair hearing, he is entitled to the services of a legally qualified person of his choice, outwith the constraints of paragraph 30 of the Framework Code as construed above. Thus he argues that the common law entitles him to legal representation by someone such as his counsel in the present proceedings.

[59] Under this banner, my attention was drawn to two first instance decisions in England. The first is ***Regina (Dr. S) –v- Knowsley NHS Primary Care Trust*** [2006]

EWHC 26 (Admin), which concerned a Primary Care Trust's procedures when considering the removal of a general practitioner from its statutory list under the relevant Regulations. The decision making agency was an independent appellate authority, acting under a statutory framework. The equation included certain guidance published by the Department of Health. This contained a provision [31.7] which, while purporting to prescribe that "… *there will be no right to legal representation*" for either party, the medical practitioner concerned could be accompanied by a legally qualified person "… *to advise them on questions of procedure, on the validity of any allegations or actions proposed during the hearing, or to take notes for the purpose of any right of appeal that is available* … [but not] *to question or cross-examine witnesses or address Panel members directly*". The two Applicants (Dr. S and Dr. Ghosh) were granted leave to apply for judicial review. The Applicants challenged a twofold determination by the Trust which, they claimed, (a) refused to permit them to be legally represented and (b) purported to confine the questioning of witnesses to Panel members only. The Trust's riposte was that the proceedings were premature and misconceived, since all questions of process, procedure and conduct of the hearing would fall to be determined by the Panel Chairperson. Each of the Applicants was a general medical practitioner against whom there were allegations of indecent assaults.

[60] The Administrative Court was seised of a number of issues. On the discrete topic of legal representation, Toulson J stated, firstly:

"[86] *If there is to be cross-examination of the complainants, that would be a powerful reason for permitting legal representation, in order to avoid the complainants being cross-examined by Dr. S himself*".

He continued:

"[93] *On the subject of legal representation, the fundamental question is whether the doctor could fairly be expected to represent himself. In many cases, that may be a quite reasonable expectation. In Dr. Ghosh's case none of the allegations made against him is individually complicated, but taken together the case is sufficiently complex (with the large number of allegations, their diverse nature and the volume of paperwork) that I would be very surprised if a doctor could do himself justice in trying to handle the case unrepresented. A helper sitting beside him would be of some but limited assistance. It would be wrong that witnesses who complain of bullying and intimidation by Dr. Ghosh should feel themselves exposed to the same risk in cross-examination by him …*".

Having observed that where there are serious disputes of fact between a witness and the practitioner concerned cross-examination is likely to be a more effective method of probing the witness's evidence than questioning by the Panel, his Lordship made the following pronouncement with regard to legal representation:

"[101] *As to legal representation, the statement in paragraph 31.7 of the DOH Advice that there will be no right to legal representation … is true in the sense that the Regulations do not give the doctor a general right of legal representation, but is liable to be understood as it was by Dr. Fraser in her letter dated 19th September 2005 on behalf of the Northumberland PCT, when she wrote that 'the DOH Guidance does not permit legal representation'. That is going too far. It may be that in many cases legal representation would be unnecessary, but* ***the question in each case must be whether the doctor can reasonably be expected to represent himself or whether legal representation is necessary in order to enable him to be***

able properly to present his case. *I do not see that this can be a matter of presumption but must depend on the circumstances, including particularly the complexity of the allegations and the evidence*".

[My emphasis].

As appears from paragraph [102], the outcome of the judicial review proceedings is not entirely clear. However, it is apparent that the court was acceding to the challenge, in this respect at any rate.

[61] The passages set out above serve as a reminder of the intensely contextual and fact sensitive nature of the common law right to a fair hearing. This is one of the dominant themes of Lord Mustill's celebrated statement in ***Doody –v- Secretary of State for the Home Department*** [1994] 1 AC 531, at p. 560:

"What does fairness require in the present case? My Lords, I think it unnecessary to refer by name to, or to quote from, any of the often-cited authorities in which the courts have explained what is essentially an intuitive judgment. They are far too well known. From them, I derive that (1) where an Act of Parliament confers an administrative power there is a presumption that it will be exercised in a manner which is fair in all the circumstances. (2) The standards of fairness are not immutable. They may change with the passage of time, both in the general and in their application to decisions of a particular type. (3) The principles of fairness are not to be applied by rote identically in every situation. What fairness demands is dependent on the context of the decision, and this is to be taken into account in all its aspects. (4) An essential feature of the context is the statute which creates the discretion, as regards both its language and the shape of the legal and administrative system within which the decision is taken. (5) Fairness will very often require that a person who may be adversely affected by the decision will have an opportunity to make representations on his own behalf either before the decision is taken with a view to producing a favourable result; or after it is taken, with a view to procuring its modification; or both. (6) Since the person affected usually cannot make worthwhile representations without knowing what factors may weigh against his interests fairness will very often require that he is informed of the gist of the case which he has to answer."

Lord Mustill's emphasis on *context* requires no elaboration.

It is also appropriate to recall another landmark pronouncement in this field, that of Lord Bridge in ***Lloyd and Others –v- McMahon*** [1987] 1 All ER 1118, at p. 1161:

"*My Lords, the so-called rules of natural justice are not engraved on tablets of stone. To use the phrase which better expresses the underlying concept, what the requirements of fairness demand when any body, domestic, administrative or judicial, has to make a decision which will affect the rights of individuals depends on the character of the decision making body, the kind of decision it has to make and the statutory or other framework in which it operates. In particular, it is well established that when a statute has conferred on any body the power to make decisions affecting individuals,* ***the courts will not only require the procedure prescribed by the statute to be followed, but will readily imply so much and no more to be introduced by way of additional procedural safeguards as will ensure the attainment of fairness***".

[Emphasis added].

[62] In ***Kulkamri –v- Milton Keynes Hospital NHS Trust*** [2008] EWHC 1861 (BQ), the proceedings followed a course more akin to that adopted in the present case. The specific complaint of the Claimant, a House Officer, was that he should have legal representation to assist him in disciplinary proceedings. He seems to have brought a private law action (as in the present case) seeking, *inter alia*, a declaration that the Defendant was in breach of contract. In the course of such litigation, he secured an interim injunction. As appears from paragraph 15 of the judgment of Penry-Davey J, the shape and thrust of the Claimant's case were closely comparable to the present action. It would appear from the terms of the judgment that there is some uniformity throughout the United Kingdom with regard to (a) the DHSSPS Framework Code and (b) the Trust's Disciplinary Code: see especially paragraphs [2] – [4]. The burden of the Claimant's case seems to have been that, having regard to various factors, he "*… cannot fairly and reasonably be expected to represent himself in order to properly present his case*": cf. paragraph [19]. The Claimant (in common with the Plaintiff in the present case) highlighted in particular the seriousness of the allegations against him; the risk of being rendered permanently unemployable; his inability to present his own defence unassisted; the consideration that the cornerstone of his defence would rest on detailed cross-examination of the complainant, whose evidence was the linchpin of the case against him; and, finally, the potential for complex legal arguments including issues concerning the appropriate burden and standard of proof.

[63] In a key passage of his judgment, the learned judge stated, at paragraph [20]:

"*In my judgment it is important to have regard to the reasons for the introduction of MHPS (and in its wake the Defendant's policy) relating to disciplinary hearings and the fact that the new procedures were the subject of negotiation by the professional bodies concerned including the BMA against a background of considerable dissatisfaction with the unsatisfactory nature of the old procedures and a necessity to introduce procedures reflecting the new statutory right to be accompanied. In my judgment considering both the background that I have indicated and the circumstances of this case I do not consider that the exclusion of legal representation was in breach of natural justice and I further conclude that in the light of the express term there is no room for the insertion or addition of an implied term to permit legal representation as part of trust and confidence in the circumstances of this case. Alternatively, in my judgment if there was such a term it has not been demonstrated that the refusal to allow legal representation on the basis that there were no exceptional reasons in this case to justify departure from the laid down procedure was unreasonable or unfair*".

The final issue addressed by the learned judge (again mirroring the present case) related to the composition of the bundle for hearing. His Lordship noted the Defendant's submission that "*… the logical conclusion is that in all domestic proceedings there will be a requirement for the High Court to micro-manage such proceedings*", with which he concurred, condemning this aspect of the Claimant's case as misconceived:

"*Temporary or permanent injunctive relief in the High Court is in my judgment an inappropriate vehicle for the management of internal proceedings by way of inclusion or exclusion of aspects of the evidence. Even if the evidence on the face of it appeared to be irrelevant and inadmissible, the High Court is not in my judgment the appropriate forum in advance of the proceedings for the resolution of such an issue.*"

The outcome was an order discharging the interim injunction and a refusal of the claim for declaratory relief. I was informed that this decision is under appeal.

[64] In my opinion, where domestic disciplinary proceedings are concerned, it will rarely be appropriate for the High Court to intervene by granting declaratory, injunctive or other relief relating to the conduct of such proceedings, in the absence of a clearly formulated issue bearing on contractual rights and obligations (as in the present case). It would be manifestly undesirable for satellite litigation of this kind to occur in the sphere of disciplinary proceedings. In the present case, the Plaintiff, effectively, invited this court to scrutinise and dictate the composition of the presenting officer's case summary and the related bundle for hearing. Moreover, the Plaintiff invited the court to intervene, initially, at a stage when attempts to resolve issues of this kind between the parties were manifestly incomplete. At this juncture, the Plaintiff has certain enduring complaints relating particularly to the composition of the bundle for hearing. In my judgment, if these issues cannot be resolved consensually to the Plaintiff's satisfaction, they will fall to be determined by the Disciplinary Panel. Moreover, these issues are concerned with discrete aspects of the disciplinary process. In my view, the ultimate question will be whether the disciplinary process is, *as a whole*, compatible with the Plaintiff's common law right to a fair hearing. The High Court will very rarely be properly equipped to make a confident and informed forecast of this matter in advance of a scheduled disciplinary hearing. I consider the present case to be no exception in this respect.

[65] Furthermore, the intrinsic undesirability of the High Court intervening in domestic disciplinary proceedings to regulate issues of this kind is underlined by the terms in which the Plaintiff seeks the second of the injunctions claimed:

"*The Plaintiff seeks an order that the Defendant be restrained from …*

(b) Adopting a disciplinary procedure … which fails to comply with the principles of natural justice and fairness".

In my opinion, an injunction framed in these terms would be devoid of any value or real meaning. It would convey nothing of substance to the audience concerned and would simply be a recipe for uncertainty and further controversy. The Plaintiff did not attempt to particularise this injunction in his Writ of Summons, Statement of Claim or Notice of Motion. Indeed, formulated thus, it was vulnerable to be struck out summarily for want of particularity.

[66] Domestic disciplinary proceedings in an employment context belong to a special category. They are not to be compared, or confused, with formal legal proceedings. They are not designed to be invested with the trappings and formalities of the latter. The golden rule which they must observe at every stage of the process is that of *fairness.* How this rule is duly observed will depend upon the individual context. Informality and flexibility, each of which is an intrinsically contextual value, are well equipped to ensure that the requirements of fairness are fully observed in any given case. In the present case, I have found that the Plaintiff enjoys a contractual right to legal representation. However, the forum of domestic disciplinary proceedings is probably not well suited, in most cases, to intrusion by lawyers. While the virtues and benefits of legal representation are not to be underestimated in many litigation contexts, these do not equate precisely with the context of the domestic disciplinary hearing. Moreover, any tendency to overlook, or undervalue, the independence,

professionalism, integrity, experience and expertise of the members of the Disciplinary Panel in this kind of case must be firmly resisted. To instance but one example in the context of the present litigation, I consider that the Panel members will be perfectly capable of ruling on the fairness, and relevance, of exploring issues bearing on the reporting of the death in question by the Plaintiff to the Coroner. In contrast, I consider that the High Court is singularly ill equipped to do so. Moreover, this would be a clear example of inappropriate micro-management.

[67] In its conduct of the forthcoming disciplinary hearing, the Panel may wish to have regard to the guidance contained in the judgment of Mummery LJ in ***Bache –v- Essex County Council*** [2000] IRLR 251:

"*(1) At the hearing the tribunal must follow a procedure which is fair to both sides. It must normally allow each side to call relevant evidence, to ask relevant questions of the other side's witnesses and to make relevant submissions on the evidence and the law.*

(2) The tribunal is responsible for the fair conduct of the hearing. It is in control. Neither the parties nor their representatives are in control of the hearing.

(3) Procedural fairness applies to the conduct of all those involved in the hearing. Just as the tribunal is under a duty to behave fairly, so are the parties and their representatives. The tribunal is accordingly entitled to require the parties and their representatives to act in a fair and reasonable way in the presentation of their evidence, in challenging the other side's evidence and in making submissions. The rulings of the tribunal on what is and is not relevant and what is the fair and appropriate procedure ought to be respected even by a party and his representative who do not agree with a ruling."

[68] In the present case, I have held that the Plaintiff is entitled to be accompanied by a companion (as defined) of his choosing at the forthcoming disciplinary hearing, *as a matter of contractual right*. In short, the Trust is bound to respect the Plaintiff's contractual entitlement. However, the Plaintiff argues that he is entitled to representation by a qualified practicing lawyer of his choice, to vindicate his common law right to a fair hearing. Having regard to all the evidence assembled before the court, which is of substantial volume, I hold against the Plaintiff on this issue. While the gravity of the charges against the Plaintiff and the seriousness of the possible consequences are beyond dispute, I am not persuaded, at this "forecasting" stage, that the complexities and burdens are such that the Plaintiff would be deprived of his common law right to a fair hearing if represented by Dr. Barclay, with his apparent credentials and experience, rather than a legally qualified person of his choice. On this issue, Mr. O'Reilly's submissions, noted in paragraph [39] above, prevail.

[69] Accordingly, the Plaintiff will have the right to be accompanied by a companion (as defined) of his choosing at the forthcoming disciplinary hearing, solely by virtue of his contractual right to this facility. Bearing in mind that the companion may be a legally qualified person, it follows that the Plaintiff's contract of employment, in this respect, confers on him a greater benefit than his common law right to a fair hearing.

VIII RELIEF

[70] On 30th October 2008, given the urgency of the matter, I delivered a synopsis of my main findings and conclusions. At that hearing, the question of relief was raised *inter partes*.

My central finding, to the effect that the Plaintiff has a contractual right to be accompanied by a companion (as defined) of his choice at the disciplinary hearing, in accordance with paragraph 30 of the Framework Code, can be related to the declaration sought in paragraph 40 of the Statement of Claim and the first of the three injunctions claimed in paragraph 41(a). I had some reservations about whether the grant of an injunction would be appropriate, bearing in mind the principle that the courts will not grant an injunction to restrain breaches of covenant in a contract of employment if to do so would be tantamount to indirectly or ordering specific performance: see ***Bean on Injunctions*** (8th Edition), paragraphs 4.01-4.05 and the cases discussed therein. While a consideration of some of these cases, such as ***Page One Records v. Britton*** [1968] 1 WLR 157, suggests that they may belong to a special category, there was insufficient time and opportunity for further detailed argument from the parties.

[71] In the circumstances, it seemed to me that the grant of declaratory relief in terms reflecting my finding regarding the plaintiff's contractual right would provide a suitable and adequate remedy, given that the Trust, a responsible public authority, could be expected to give practical effect to such an order, notwithstanding that a declaration (to be contrasted with an injunction) is not an executory judgment. Confirmation was then provided on behalf of the Trust that it would do so. In the circumstances, I determined that the court would make a declaration reflecting the conclusion expressed in paragraphs [50] - [53] above.

Costs

[72] I remind myself of the discretion conferred on the court by Section 59 of the Judicature (Northern Ireland) Act 1978, the general rule [enshrined in RSC Order 62, Rule 3(3)] that costs should follow the event and the statement of Carswell LCJ in ***Re Kavanagh's Application*** [1997] NI 368 that "… *the discretion should be exercised along well settled lines*" [p. 382]. The immediately succeeding quotation from the judgment of Atkin LJ in ***Ritter –v- Godfrey*** speaks of "*a wholly successful defendant*". In exercising my discretion, I take in to account the following factors in particular:

(a) The declaration which I have determined to make does not reflect the relief sought by the Plaintiff: rather, it constitutes an outcome which the Plaintiff did not seek.

(b) I have rejected the construction of paragraph 30 of the Framework Code advocated by the Plaintiff.

(c) The Plaintiff has failed in the other aspects of his challenge to the disciplinary process: see paragraphs [31]-[32], [41] and [64] above.

(d) The evidence indicates a failure by the Trust to take steps to incorporate the Framework Code into contracts of employment, in contravention of the "Directions" and the 1991 Order: see paragraphs [44] – [50] above. Stated succinctly, the failure of the Trust's Code to properly implement the departmental Framework Code is unlawful.

(e) I have held that the Trust is not entitled to impose on the Plaintiff a representative of the Trust's choosing.

(f) However, subject to (e), the Trust's willingness to allow the Plaintiff to be represented by Dr. Barclay does fall within paragraph 50 of the Framework Code, as construed in this judgment.

Overall, I consider that there is no clear winner in this litigation. There has been some limited success and failure on both sides. Moreoever, the declaration to be made has certain elements of elucidation and education, in circumstances where the Trust does not appear to have been aware of its statutory obligation to give effect to the departmental Directions. I am satisfied that, in all the circumstances, the fair and reasonable exercise of the court's discretion is to make no order as to costs *inter-partes*.

[73] Finally, I record my thanks to counsel for the quality of their submissions, both written and oral.

		Management Team, and CEO in relation to Doctors and Dentists in Difficulty.

2.3 Until 1st April 2007, there were 4 separate Trusts covering what now makes up the Southern HSC Trust. These were: Craigavon Area Hospital Group Trust; Newry and Mourne Trust; Armagh and Dungannon Trust; and Armagh Community HSS Trust. Each Trust had a Medical Director and each of these persons is, I understand, now retired. In the circumstances, I am fully reliant on information provided by others who were involved in, or have some awareness of, relevant events in these predecessor Trusts. In this regard, I am told by Ms Vivienne Toal that Myrtle Richardson (retired) was Director of HR in Craigavon Area Hospital Group Trust and is likely to have had greatest knowledge at the time of what occurred. I understand that Urology Services were part of the Craigavon Area Hospital Group Trust under legacy arrangements. Records from that time are not available; I understand that, when an approach was made to the Department of Health by Mrs Zoe Parks, they explained that they have not retained copies on their electronic systems. *Please see:*

- *1. E re Notifications from Trusts re Implementation of MHPS*
- *2. Handling Concerns about the Performance of Healthcare Professionals*

3. Provide a copy of any forerunner (or any earlier iteration) of the Trust's internal policy, "*Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance*" dated 23 September 2010 ("the 2010 Guidelines").

3.1 I am not aware of, nor has the Trust been able to locate, any earlier version of this specific document other than a draft version from September 2010. I have attached this as well as other documents that would have existed at the time. *Please see:*

Stinson, Emma M

From: OKane, Maria
Sent: 30 August 2022 16:00
To: Stinson, Emma M
Subject: q1 section 21 : 51 attachment

From: Parks, Zoe <Personal Information redacted by the USI>
Sent: 30 August 2022 15:57
To: OKane, Maria <Personal Information redacted by the USI>
Subject: FW: Quick Query

From: Parks, Zoe
Sent: 27 July 2022 13:25
To: Toal, Vivienne <Personal Information redacted by the USI>
Subject: FW: Quick Query

Just to let you know I spoke to Katherine in the Dept. re the confirmations from NI Trusts around MHPS by 31 January 2006. They were asked something similar by PI and advised that they don't hold copies of these responses from previous Trusts as this was before their new electronic system was introduced. The paper copies have been destroyed in line with records management.

From: Ferguson, Katherine <Personal Information redacted by the USI>
Sent: 26 July 2022 09:07
To: Parks, Zoe <Personal Information redacted by the USI>
Subject: RE: Quick Query

Hi Zoe,

Tried calling there but got your voicemail, I'm about most of today if you want to give me a buzz, though I've meetings 10-11, 11.30 – 12 and 3.30-4.30#

Best bet is the landline and my mobile signal is rubbish

Thanks

K

Katherine Ferguson
Pay & Employment Unit

tel – Personal Information redacted by the USI ext – Personal Information
mobile – Personal Information redacted by the USI

have the effect of directing all HSS bodies, from 1 December 2005, to comply with MHPS.

23. Under paragraph 3 of the Directions, HSS bodies were required to notify the Department by 31 January 2006 of the action they had taken to comply with MHPS. Unfortunately, the Department cannot locate in its electronic records the correspondence from HSS bodies communicating the action they took to comply with MHPS. This is most likely due to the fact that the Department's current electronic records system (first named TRIM, now called Content Manager) was only put in place in around 2007/2008.

24. On 6 June 2022 the Department initiated a search of hard copy files. A search for "*Maintaining High Professional Standards in the Modern HPSS: A framework for handling of concerns about doctors and dentists in the HPSS' ("MHPS") in November 2005*" found that two paper files had been created, but that both have since been destroyed under records management practices. Specifically, file BS/117/04 was destroyed on 20 May 2015; and file BS/660/06 was destroyed on 1 August 2016.

25. In order to conduct as comprehensive a search as possible, further searches of the file registry were conducted under the following titles, though without success:

    (a). Directions on Disciplinary Procedures 2005.

    (b). HSS(TC8) 6/2005

    (c). Pay and Employment unit – correspondence (or emails) – 2005

    (d). Pay and Employment unit – correspondence (or emails) – 2006

26. The introduction to MHPS (paragraph 1, page 1) states that the framework is "*for handling concerns about the conduct, clinical performance and health of medical and dental employees"*. Paragraph 4, page 1 outlines that the framework is in six sections and covers:

We'll look at those in the course of this afternoon.

You are currently Director of Human Resources and Organisation Development for the Southern Trust; is that correct? 10:04

A. That's correct. Yes.

12 Q. You took up that role on a permanent basis on 21st September 2016?

A. That's correct.

13 Q. It's right in the middle, I suppose, of the Oversight Committee process affecting Mr. O'Brien; isn't that right? 10:04

A. Yes, that's correct. The process commenced when I was Acting.

14 Q. You were Acting Director, if I can just shorten it to HR without injury to your full job title? 10:05

A. That's fine.

15 Q. You were Acting Director of HR from 15th August; isn't that right?

A. That's correct, yes. 10:05

16 Q. You had been employed in what we sometimes refer to as the Legacy Trust. That was one of the legacy Trusts, I suppose, Craigavon Health and Social Services Trust which was to, with other Trusts, morph into the Southern Trust following the review of public administration in Northern Ireland? 10:05

A. Yes, it was like Craigavon Area Hospital Group Trust, yes.

17 Q. You had been employed in that Trust from 1998 and had

Southern Trust forms in 2000 and?

A. Seven.

48 Q. Seven. Is it fair to say that you weren't aware of any local guideline in 2005 after the birth of MHPS?

A. No, I am not aware of any in legacy Trust or Southern Trust. I think when it probably came to light was in 2010. I think the discussions around the Responsible Officer role came in on that date, and I think that's then what, presumably, prompted the conversations within Southern Trust around needing to develop the Trust guidelines. But, no, I don't remember anything prior to that. 10:30 10:31

49 Q. You've told us in your witness statement that Kieran Donaghy, and you've mentioned it already, sent you two review documents, one authored by Anne Brennan, who was, at the time, senior manager in the Medical Director's office? 10:31

A. That's correct.

50 Q. And Debbie Burns, who was Assistant Director in?

A. Performance Improvement, I think, yes. 10:31

51 Q. That's right. You were asked to review that. Let me just pull up Mrs. Burns' paper. Is it fair to say, and I mean no disrespect to Mrs. Brennan's paper, but Mrs. Burns' paper became the kind of prototype or provided the architecture for what was eventually adopted? 10:32

A. Yes, that --

52 Q. Her paper, just to assist you, WIT-41225. The draft, obviously. If we scroll down. We can see at

Southern Health and Social Care Trust

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

23 September 2010

1.0 Introduction

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

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

1.3 The MHPS framework is in six sections and covers:

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

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

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

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

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

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

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

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

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

Annex C
SHSCT Disciplinary Procedure

Annex D
SHSCT Clinical Manager's MHPS Toolkit

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

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

2.2 Concerns[1] should be raised with the practitioner's Clinical Manager – this will normally be either the Clinical Director or Associate Medical Director. If the initial report / concern is made directly to the Medical Director, then the Medical Director should accept and record the concern but not seek or receive any significant detail, rather refer the matter to the relevant Clinical Manager. Such concerns will then be subject to the normal process as stated in the remainder of this document.

2.3 Concerns which may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant operational Director. They will then inform the Chief Executive and the Medical Director, that a concern has been raised.

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

2.5 The Chief Executive will be responsible for appointing an Oversight Group (OG) for the case. This will normally comprise of

[1] Examples of Concerns may include: - when any aspect of a practitioner's performance or conduct poses a threat or potential threat to patient safety, exposes services to financial or other substantial risks, undermines the reputation or efficiency of services in some significant way, are outside the acceptable practice guidelines and standards.

the Medical Director / Responsible Officer, the Director of Human Resources & Organisational Development and the relevant Operational Director. The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust's handling of concerns.

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

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

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

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

2.8 The Clinical Manager and the HR Case Manager will notify their informal assessment and decision to the Oversight Group. The role of the Oversight Group is to quality assure the decision and recommendations regarding invocation of the MHPS following

informal assessment by the Clinical Manager and HR Case Manager and if necessary ask for further clarification. The Oversight group will promote fairness, transparency and consistency of approach to the process of handling concerns.

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

2.10 If a formal investigation is to be undertaken, the Chief Executive in conjunction with the Oversight Group will appoint a Case Manager and Case Investigator. The Chief Executive also has a responsibility to advise the Chairman of the Board so that the Chairman can designate a non-executive member of the Board to oversee the case to ensure momentum is maintained and consider any representations from the practitioner about his or her exclusion (if relevant) or any representations about the investigation.
Reference Section 1 paragraph 8 – MHPS 2005

3.0 MANAGING PERFORMANCE ISSUES

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

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

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

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

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

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

Appendix 6
Role definitions

3.2 The processes involved in managing performance issues move from informal to formal if required due to the seriousness or repetitive nature of the issue OR if the practitioner fails to comply with remedial action requirements or NCAS referral or recommendations. The decision following the initial assessment at the screening stage, can however result in the formal process being activated without having first gone through an informal stage, if the complaint warrants such measures to be taken.

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

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

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

Appendix 1

Step 1 Screening Process

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

→ Clinical Manager/Operational Director informs:

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

↓

Chief Executive appoints an Oversight Group – usually comprising of:

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

↓

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

↓

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

↓

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

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Formal Investigation
- Exclusion / Restriction

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

Appendix 1

Step 2 Informal Process

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

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

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

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

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

Referral to NCAS

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

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

Appendix 2

Formal Process

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

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

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

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

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

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

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

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

Case Manager must then make a decision on whether:

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

Appendix 3

Conduct Hearings / Disciplinary Procedures

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

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

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

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

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

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

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

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

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

Appendix 3a

Clinical Performance Hearings

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

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

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

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

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

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

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

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

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

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

Appendix 3a

Clinical Performance Hearings

During the hearing - witnesses:

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

During the hearing – order of presentation:

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

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

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

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

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

Appendix 4

Appeal Procedures in Clinical Performance Cases

Composition of the panel – 3 people:

- **Chair**

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

- **Panel 1**

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

- **Panel 2**

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

Advisors to the Panel:

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

Timescales:

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

Powers of the Appeal Panel

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

Documentation:

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

Appendix 5

Restriction of Practice / Exclusion from Work

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

Immediate Exclusion

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

↓

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

→

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

↓

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

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

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

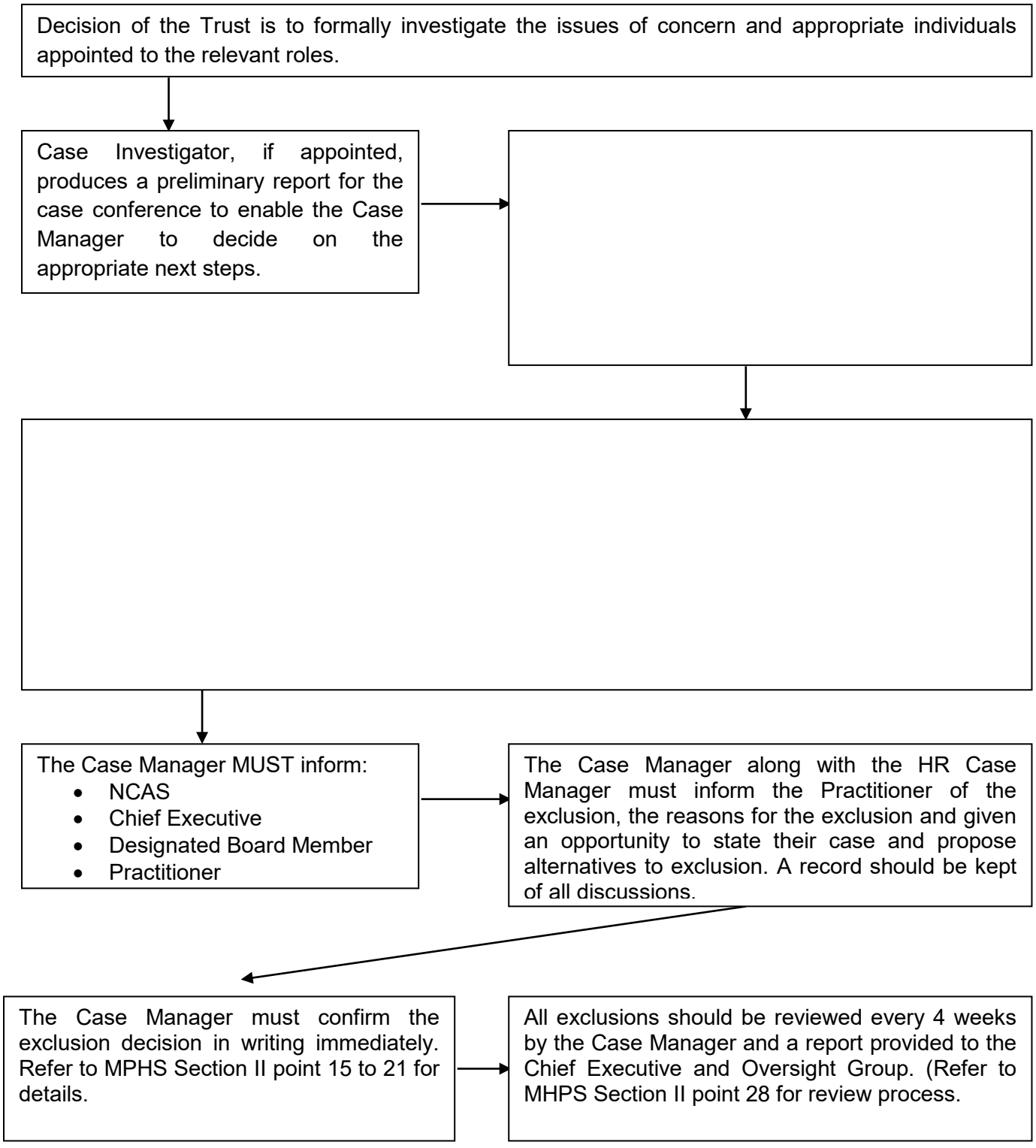
→

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

Appendix 5

Restriction of Practice / Exclusion from Work

Formal Exclusion



Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

Clinical Manager

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

Chief Executive

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

Oversight Group

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

Formal Process

Chief Executive

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

Case Manager

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

Case Investigator

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

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

Non Executive Board Member

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

Urology Services Inquiry

(Attachment folder S21 49 of 2022- Attachment 25- 2010.09.23 b Slides att to Email from S Hynds to V Toal re ML Network next day)

(Attachment folder S21 49 of 2022- Attachment 26- 2010.09.23 c Email from VToal to S Hynds with slides for ML Network next day)
(Attachment folder S21 49 of 2022- Attachment 27- 2010.09.23 d Slides att to Email from VToal to S Hynds _ ML Network next day)

(Attachment folder S21 49 of 2022- Attachment 28- 2010.09.24 e Email from VToal to S Hynds re ML Network slides with att)
(Attachment folder S21 49 of 2022- Attachment 29- 2010.09.24 f Slides att to Email from VToal to S Hynds re ML Network presentation)

7(x) The Trust Guidelines 2010 were intended to sit alongside and be read in conjunction with "Maintaining High Professional Standards in the Modern NHS" DHSSPSNI (2005) **This can be located at Relevant to HR / Reference no 67 / TC8 6.2005 Maintaining High Professional Standards** and the NCAS 2010 guide "How to conduct a local performance investigation" **This can be found at Attachment folder S21 49 of 2022 - Attachment 30 - 2010.01.01 NCAS publication_ How-to-conduct-a-local-investigation.pdf,** as per para 1.8 of the 2010 document. Their purpose was to set MHPS as a framework into the Southern HSC Trust context in terms of clarification of who fills which roles within the Trust, and was in response to para 11, page 3 of MHPS, which refers to HSS bodies having procedures in place for dealing with concerns about an individual's performance. It was never the intention to replace MHPS with the Trust guidelines.

7(xi) I do not believe I obtained legal advice on the Trust Guidelines in 2010. I do not have any email record of a draft being sent to the Directorate of Legal Services. To be clear for the purposes of being definitive in my Section 21 response I asked Siobhan Hynds by telephone on 23rd May 2022, if she sought legal advice, and she advised me that she did not have any email record of having done so either. On reflection, I should have requested that

my first brief as case manager. How is that problem of gap in training addressed today or how would you go about that?

A. I suppose we now have, in terms of that training plan, a regularity with it, but, from the perspective of working with somebody. Now the HR manager will be sitting down with them and actually going through, you know, what the actual role is, and they will be there at their elbow trying to, you know, make sure they are worked through the actual process and kept right. It is very much in line with making sure the HR case manager is working very closely with them. That's how we try to close that gap. 10:50 10:50

69 Q. In terms of the guidelines, then, that were developed and the relationship with MHPS, you've explained that -- and this is in your witness statement at WIT-41033. The guidelines were intended to sit alongside and be read in conjunction with MHPS. It was never the intention to replace -- 10:51

A. No. 10:51

70 Q. -- MHPS with Trust guidelines.

In terms of your experience of interacting with the guidelines/MHPS by 2016 when you were Acting Director, and then Director, and you came on to the Oversight Committee, you've referred in your witness statement -- and I don't wish to deal with the substance of these cases in any way -- but you've referred in your witness statement and your recent additional statement to, 10:51

2018

Southern Health and Social Care Trust

Quality Care - for you, with you

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

October 2017

INTRODUCTION

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

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

1.3 MHPS is in six sections and covers:

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

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

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

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

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

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

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

2.0 WHAT IS A CONCERN?

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

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

MHPS Section1 para 2

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

- Failure to report concerns

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

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

2.5 WHO TO TELL?

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

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

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

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

3.1 AS CLINICAL MANAGER - WHAT ACTION DO I TAKE?

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

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

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

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

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

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

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

3.2 DIFFERENCE BETWEEN SCREENING OF CONCERNS AND FORMAL INVESTIGATION

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

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

3.3 SUPPORT FOR DOCTORS DURING SCREENING

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

3.4 WHAT HAPPENS AT THE END OF SCREENING PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 SUMMARY

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

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

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

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

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

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

Appendix 6
Role definitions

Appendix 1

Step 1 Screening Process

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

→ Clinical Manager/Operational Director informs

Early in process
- Practitioner

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

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

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

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

→ No Action Necessary, Reason documented and held on file

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

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

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

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

Appendix 1

Informal Remedial Action

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

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

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

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

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

Referral to NCAS

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

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

Appendix 2

Formal Investigation Process

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

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

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

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

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

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

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

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

Case Manager must then make a decision on whether:

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

Appendix 3

Outcome of Formal Investigation:
Conduct Hearings / Disciplinary Procedures

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

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

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

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

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

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

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

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

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

Appendix 3a

Outcome of Formal Investigation:
Clinical Performance Hearings

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

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

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

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

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

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

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

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

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

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

Appendix 3a

Clinical Performance Hearings

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

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

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

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

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

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

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

Appendix 4

Appeal Procedures in Clinical Performance Cases

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

Composition of the panel – 3 people:

- **Chair**

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

- **Panel 1**

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

- **Panel 2**

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

Advisors to the Panel:

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

Timescales:

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

Powers of the Appeal Panel

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

Documentation:

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

Appendix 5

Restriction of Practice / Exclusion from Work

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

Immediate Exclusion

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

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

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

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

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

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

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

Appendix 5

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

Formal Exclusion

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

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

→

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

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

↓

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

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

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

↓

The Case Manager MUST inform:

- NCAS
- Chief Executive
- Designated Board Member
- Practitioner

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

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

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

Appendix 6

Role definitions and responsibilities

Screening Process / Informal Process

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

Formal Process

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

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

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

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

Non Executive Board Member

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

paragraph 4 about the need for before deciding action is required in relation to poor performance all concerns and reports of potential issues should be screened. If we go to paragraph 5 it explains that a process that's contained within MHPS itself, 10:33
second bullet point: "An initial verification and assessment of the issues raised should be undertaken by the Clinical Manager of the practitioner", and that is defined as the Clinical Director or Associate Medical Director. 10:33

A. Mm-hmm.

53 Q. "This assessment should be presented to decide on whether an informal or formal investigation is required".

10:33

Then it introduces, at Paragraph 6, the concept of an Oversight Group.

It starts life, as would appear from these tracked changes, as a decision making group. Was it you who 10:33
came up with the concept of an Oversight Group?

A. I think Debbie Burns -- and I'm not clear, I cannot recall why Debbie would have been involved in this. I think she worked very closely with Mairéad McAlinden at the time from a performance perspective. It may 10:34
have been that Mairéad had asked Debbie to try to look at this, but I'm not 100% sure. But it is clear from that document that NCAS --

54 Q. Sorry to cut across you, there's other pages, perhaps.

We'll just maybe scroll down.

A. It is clear that it was following the NCAS 2010 document, and within that NCAS guidance I think that come out in January 2010, which was around, you know, local performance investigations, that in primary care -- not secondary care but in primary care there was a reference to a decision making group. That was obviously linked probably to the size of, sort of like, primary care, maybe GP practices, and things like that. I think that is where maybe some of the confusion there has come in because it was in the context of primary care in that particular NCAS document.

55 Q. If we maybe just pause to let the Inquiry see that. The NCAS guide to which you refer is WIT-41399. As you say, the focus is on primary care. This is an NCAS produced document that came in in 2010.

A. That's correct. Yes.

56 Q. If we just scroll down to 41399, we can see you were making the point that when -- you were making the point that when looking at Mrs. Burns' paper and you're seeing the reference to a decision making group or a DMG, you recognise that --

A. Yes.

57 Q. -- as having an origin, perhaps, in this document.

We see here in handling performance concerns in primary care, NCAS suggests the use of a decision making group supported by a professional advisory group with membership suggestions made for both groups in

a primary care organisation using this structure the DMG would usually make the decision to commission a local investigation or take some other action such as referral to the police, etcetera.

10:37

In this text they're putting the function of making the decision in the hands of the DMG and, ultimately, that's not the path that was followed within your guidelines when introducing the concept of the Oversight Group. Can you just explain that for us? 10:38

A. Yes. A lot of discussions -- I wasn't party to the discussions between Dr. Loughran, Mrs. McAlinden, Kieran Donaghy, but my understanding was that when they looked at Debbie's draft and looked at the decision making group, I don't know who would have said, 'well, 10:38 that's for primary care', but there was obviously something about that concept of some sort of overarching tier that those members of the senior management team wanted to incorporate in. I think that's when it was amended then. You'll see in the 10:38 track changes to the Oversight Group. I think that's the origins of it, but I wasn't party necessarily to those group conversations or certainly at senior management team. But I would have been aware that from, emanating from those discussions the preference 10:39 was to have some sort of tier there, and that's why that was incorporated into my draft of the guidance.

58 Q. We will come in a minute to just look at the guidelines, but the concept of an Oversight Group, as

described in your witness statement, WIT-41052, you say:

"I can recall from discussions with Kieran Donaghy" -- just the top of the page -- "that there was a view from the Chief Executive and Directors that a form of oversight arrangement would be needed to assure consistency of approach, and fairness across MHPS processes. Therefore, the concept of the oversight group was included by me in the Trust guidelines which were eventually published on 23rd October." 10:39 10:40

A. That's right.

59 Q. So, it's all your fault!

The concept, as imagined at that time was, almost by definition, a group comprised usually of the Medical Director, somebody from HR, usually the HR Director, and a person from the Service, so the Directorate, usually the Director. 10:40

A. Yes, that's right. 10:40

60 Q. Would, if you like, sit on a tier receiving information from the Clinical Manager who would have a strong view, if not a decision or a recommendation, on which way to take a performance issue, whether informal, formal, or no action required. We'll look at the fine detail. 10:41

A. Mm-hmm.

61 Q. It was the role of the Oversight Group to ensure that that was done in a way that was consistent, fair, transparent. It was a quality control type function as

opposed to an investigatory screening or decision making function?

A. That's how it was envisaged, yes.

62 Q. It appears to have been realised that there was training requirements around this. You go to WIT-41326. You mentioned this earlier. 24th September 2010. 10:41

"The session is designed to provide an opportunity to explore how we handle performance concerns about doctors and dentists". 10:42

To the best of your recollection, is this the first training that the Trust has brought forward in the area of MHPS and the local framework? 10:42

A. It's the first I'm aware of, yes. I can't say for sure there wasn't anything before that, but it's the first I'm aware of.

63 Q. If we just scroll down. Dr. Fitzpatrick from NCAS attends and yourself and Mrs. Hynds do a piece on the guidance you have just written, or probably a better word is to say you contributed to it and overseen its delivery. 10:43

We spoke about training a little bit earlier in the context of what the NCAS guide says and what the MHPS says. It's recognised by MHPS that there are training requirements in this. Maybe if we just pull up the reference. WIT-18534. At the top of the page it says: 10:43

a further oversight meeting of the same members on Personal Information redacted by the USI as outlined above. I was an apology for the September meeting also; however, Siobhan Hynds attended, in addition to Helen Walker. It was determined by the Oversight Group members that there was no evidence of any substance to the concerns raised in the anonymous letter. Given I was an apology for both meetings I was not directly involved in this case; I received verbal updates from Helen Walker and Siobhan Hynds and was copied into emails with notes of the meeting from Simon Gibson.

7(xiii) In early 2017, Siobhan Hynds, then Head of Employee Relations, and I had a discussion about needing to review the 2010 Trust Guidelines. I believe this conversation was linked to our reflections on the case involving Mr O'Brien, and in particular the difficulties at the early stages of the process involving the oversight group, which had led to confusion about roles and responsibilities in the management of the concerns. I refer to these difficulties in my response at 26(iii) below. On the back of this conversation in early 2017, Siobhan Hynds emailed Annette Murphy, HR Assistant in Employee Relations on 21st February 2017 to arrange a meeting to "*review recent MHPS cases and to review our Trust Guidance"*. **This can be found at Attachment folder S21 49 of 2022- Attachment 31.** Annette Murphy emailed Siobhan Hynds, Zoe Parks (Medical Staffing Manager), Lynne Hainey (HR Manager), Helen Walker (Assistant Director of HR aligned to Acute Services) and myself on 22nd February 2017 to confirm the date of the meeting as 2nd March 2017. **This can be found at Attachment folder S21 49 of 2022- Attachment 32.** Zoe Parks had just returned from Personal Information redacted by the USI at the end of February 2017. I can recall working through the 2010 Trust Guidelines at the meeting and the main discussion was about the need to remove any reference to the 'oversight group' to ensure our implementation of it for managing concerns was entirely in line with MHPS framework. I refer to our concerns regarding the Oversight Group being part of the process in more detail in my response to Question 26(iii) below.

I. Outline the systems within the Trust which established the clear audit route for initiating and tracking the progress, cost and resulting action with regard to an investigation under Section I of MHPS.

II. Provide evidence of what steps the Trust undertook to audit the investigation conducted in relation to Mr. Aidan O'Brien under Section I of MHPS, with particular reference to the progress of the investigation, the cost and resulting action.

(I) Outline the systems within the Trust which established the clear audit route for initiating and tracking the progress, cost and resulting action with regard to an investigation under Section I of MHPS.

8.1 There has, to the best of my knowledge and understanding, been no formalised audit process for initiating and tracking progress, cost and resulting action with regards to an investigation under Section I of MHPS.

8.2 The system that previously kept and continues to keep, an audit trail, tracking progress on cases, is the Trust Oversight Group.

8.3 All formal cases under MHPS also have a Non-Executive Director aligned, as per MHPS, one of whose duties is to oversee the case to ensure momentum is maintained (see MHPS Section I, page 6, para 8, 2nd bullet).

8.4 HROD – MDO meetings recorded updates on the progress of these cases. This was brought together into a formal structure in the course of 2019, realised through the establishment of the Doctors and Dentists' Oversight Group in May 2020 on Zoom and monthly thereafter, following a developmental meeting with Northern Trust in November 2019. The implementation was delayed significantly because of the impact of the Covid 19 Pandemic and the availability of key staff to attend meetings.

8.5 The current process tracks initiation, progress and resulting actions of the MHPS process but does not currently track costs as most of the work on this is carried out in house and, since the review of Medical Leadership structures, forms part of the governance responsibilities of senior medical leaders and clinical managers in the Trust.

A. Yeah. As I mentioned earlier, we had recognised as colleagues that reviewing long waiting patients of Mr. O'Brien's where there was, perhaps, no correspondence was more of a challenge and took longer and, as a result, the clinic template, the numbers of patients or the time per patient that was assigned was adjusted to reflect that.

60 Q. Did you go to Mr. Mackle as well or was it Mrs. Corrigan reporting to Mr. Mackle?

A. I don't have a clear recollection. I think it would have been a conversation that we would have had about them specific clinics but I don't have a specific recollection about it.

61 Q. It would appear, at least from what they are saying, that this led to a meeting with Mr. O'Brien in March 2016 that called upon him to address some of these issues and then, by the end of that year, 2016, the MHPS investigation was about to be launched. At that time, running simultaneously with those conversations, was the investigation into the Patient 10 SAI. Into the following year then, you and your colleagues in the team were asked to do some further work in relation to the Triage issue; isn't that right?

A. Yeah. So into 2017, we triaged for the first time those referrals that were in the filing cabinet.

62 Q. As a result of that, a number of cases were identified as being cases that, had they been triaged in 2015 and 2016, they would have been red-flagged, or they ought to have been red-flagged?

To what extent was that a real problem or was it maybe just a small problem that you could easily work around?

A. Well, it's not really -- it's quite a big problem. In patients who have rather thick notes it can be difficult to find exactly where doctors write their notes. Mr. O'Brien wrote notes but they were always, probably for his benefit than anybody else coming afterwards, you know, they were short, they were a few lines long. So he obviously knew what he was trying to say but anybody else coming in, 2 or 3 lines may not be enough to give the whole picture of what is going on, particularly if there isn't a letter. 10:50 10:50

50 Q. So the gap was the letter, as you saw it, that was the important communication tool so that you would understand what would come next for the patient? 10:51

A. Yes. I found that very difficult because I had been brought up doing correspondence for everything, so I found it very strange.

51 Q. Another feature of Mr. O'Brien's practice that we have heard about in evidence was the not irregular occurrence whereby patient charts wouldn't be available in the hospital when a patient perhaps came in as an emergency or where he or she was coming into clinic. Was that something you experienced? 10:51

A. It was something I was aware of and, again, something I found very strange because I trained in Oxford and one of the urologists there has a big medicolegal practice and we were constantly reminded that it should be a never event to take notes outside the hospital. 10:51

Patient Notes

65. With regard to the concern of Mr O'Brien taking patient notes to his own home and retaining them there for long periods, this was a concern from a number of perspectives. In the first instance, patient notes contain personal and private information. From the perspective of information governance, all patient notes should be secure. Holding notes at home therefore was an information governance risk .Secondly, when a patient attends our emergency departments, access to patient notes are required to assist accurate clinical assessment. Not to have patient notes available in the hospital for this purpose was a risk to patient safety. It is important to say that, since the introduction of electronic methods of medical recording as in the Northern Ireland Electronic Care Record, this particular concern is now not so important from this perspective, but that was not the case before the introduction of NIECR. Finally, patients attend many different services and specialties in the Trust. The Medical Records department prepared for outpatient clinics by ensuring that all patients' notes were available for the medical team at each clinic. On a number of occasions, they would not be able to find patient notes as they were at Mr O'Brien's home. Again, not only was this frustrating for the clinical team attempting to see a patient without notes but again had a direct impact on patient safety and care. However, the NIECR system has assisted in this regard.

66. Mr O'Brien did return notes on request, and we had no way of knowing how many charts were in his home. However, despite many conversations regarding the need to keep patient notes on the hospital premises or return them immediately if it was necessary to take them home, concerns were still raised periodically by the medical records team. (This issue is also addressed in my response to Questions 24, 34, 35, 37, and 39-41 below)

No Record of Care, Treatment, or Diagnosis

67. In 2015 a new concern emerged with regard to the practice of Mr O'Brien. By that time the additional consultants had started as members of the urology team. They had experience working in England and were working both to develop the Urology service and assist in reducing the waiting times for patients and in

121. The Complaints Department received concerns from patients and relatives. A complaint would be sent out to the relevant team for completion, a reply would be drafted by, I believe, Heather Trouton and then ultimately signed by the Acute Director. Significant clinical complaints would be discussed at the Divisional and/or Acute Directorate governance meetings.

122. For the most part, the system worked. However, on reflection it is easy to see that, for example, our systems for monitoring triage were not sufficient. Because of repeated breaches, a system was introduced by Debbie Burns whereby the booking centre placed the patient on the out-patient list according to their GP's grading to ensure chronological booking. Following this, however, oversight of the triage compliance by Aidan O'Brien was not performed. The system for tracking of referrals has now been improved by the introduction of electronic triage using NIECR (Northern Ireland Electronic Care Record). Following the changes re booking of outpatient referrals I was not made aware of any delays in triage and it was only the raising of concerns by Aidan O'Brien's colleagues, while performing validation clinics in late 2015, that ultimately led to the investigation into his practice.

[37] Did those systems or processes change over time? If so, how, by whom and why?

123. I don't recall any significant changes in the systems with time.

[38] How did you ensure that you were appraised of any concerns generally within the unit?

124. I held regular meetings with the Head of Service, Assistant Director, Director and Lead Clinician. I had good working relations with nearly all staff including both medical and non-medical. With Heather Trouton and I reviewed any DATIX and any significant complaints received in the directorate.

1:1 Esther 21/12/15.

- Surgical Workshop - Plan 2016.

- Urology - AOB
  - Charts
  - No PR conke letters.
  - Triage.

  } Plan letter - 1 month improve.

- Emergency surgeon - Interviews 8th Jan
- Breast Surgeon - .. Feb.
- General Surgeons x 2 UHH - In progress advert.
- ENT Mr Hall replacement -

Additional mobile theatre - Ronan advises he will arrange visit Musgrave Jan 2016 - [redacted] will attend.

- Need to advertise internally 2 Clinical Directors EOI. Jan 2016.

- Finance 677k underspent to date - that will be eroded will Optham retraction + Agency Spend - Still should break even.

- Review + clear policy on core staff moving wards. - Way forward. - Bank staff too great a role at present - my opinion.

- Staffing - Still no additional staff until Feb - limited. - My to follow up with bank + agency.

1.2. I was Medical Director of the Southern Health and Social Care Trust from July 2015. I would have been responsible for professional matters relating to all doctors within the Trust. In this role I would have overseen the appraisal process across the Trust for all doctors. I would have been responsible for the training of doctors at all grades within all units in the Trust. I would have overseen the job planning process for doctors. I also had specific responsibility for Infection Control issues in the Trust. I had, however, no direct operational responsibility for the day to day management of the Urology service. That would have been the remit of the Acute Services Director (Mrs Gishkori). A complete list of my duties and responsibilities is provided in my Medical Director's job description which has been provided.

1.3. I fulfilled the function of the Responsible Officer (RO) for medical registration and revalidation in keeping with General Medical Council Guidance including that of Mr O'Brien.

1.4. Mrs Trouton (Assistant Director) has stated in her 5 June 2017 witness statement to Dr Chada (Case Investigator) as part of the MHPS investigation into Mr O'Brien that I was informed of the triage and other issues in a meeting on 11th January 2016 (see TRU-00797 at para 13). She has stated that, at that time, I advised her to write formally to Mr O'Brien concerning the issues. I cannot recall the details of this meeting. At that time, I would have assumed that the matter had been followed up within the Service Directorate and that I would have been informed had there been any further difficulties. I was not involved in the issues regarding Mr O'Brien again until Mr Haynes spoke to me in Early September 2016.

1.5. Mr Eamon Mackle, Associate Medical Director, and Mrs Heather Trouton (Assistant Director) met with Mr O'Brien, to outline concerns regarding his clinical practice. Mr O'Brien was provided with a letter dated 23 March 2016 detailing these concerns and asking him to respond (apparently in line with what had been discussed between Mrs Trouton and myself in January 2016). I was not privy to the March 2016 meeting or letter at the time. I became aware of them and what had or had not happened in the period since early 2016 at an Oversight Committee meeting in September 2016

seen. The numbers being upgraded were not that many and I felt the risk was relatively small for the one that may slip through. New urology colleagues were not willing to let him not triage.

13. I was involved in the conversation regarding the 23 March 2016 letter which was issued to Mr O'Brien. Mr O'Brien's general way of doing this is maverick. Every Director knew but nothing moved. I felt with the newly appointed Medical Director things might progress. There was a meeting held with Dr Wright on 11 January 2016 at 10 am and the concerns were outlined to him and I took his advice so we formally addressed the issues via a letter.

14. Some time ago Eamon Mackle tried to address the issues but Dr Rankin had said not to do anything further because a complaint had been received accusing Eamon Mackle of bullying and he was told he should not address further issues with Mr O'Brien. Eamon Mackle appointed Robin Brown to be a go between with Urology. Mr Brown made attempts too. Improvements were short term but then he went back to his behaviours again. There was a general view that Eamon Mackle was unable to deal with the issues because he was told not to. In my opinion Mr Young and Mr Brown felt uncomfortable holding Mr O'Brien to account.

15. I feel, their view was that he is a very intelligent man and a good doctor, therefore we could overlook small things. Trying to get peer and medical management support to deal with the issues was difficult to do.

16. The letter was sent to address issues regarding not triaging, his review backlog and notes at home. More recently there has been new appointments made and so there is a bigger urology team and there are members who were willing to peer challenge. The letter was given to Mr O'Brien and the expectation was that he would set out a plan as to how he was going to deal with the outstanding work.

17. I moved post on 1st April 2016, so I left it with Esther Gishkori and Ronan Carroll to deal with the action plan. I got nothing back directly from Mr O'Brien.

18. Mr O'Brien was outwith other Consultants I dealt with. I didn't come across any other surgeon who didn't agree with or partake in triage.

19. I know there was an issue with Mr O'Brien taking notes home because some were missing and Martina Corrigan had to chase these. Mr O'Brien was told he should not have notes at home. He was also told by Mr Young and Mr Brown. I shared an email of 22 January 2015 as an example of this issue which is appended to this statement. Mr O'Brien would bring them back but the process started again. I didn't know the number of charts he had or if it was a constant trickle. He should not have had any at home.

20. In respect of TOR 3, I was unaware that dictation was an issue until March 2016 when colleagues started doing validation of backlog. There has always been a review backlog in Urology but they have tended to hold on to patients to review the clinical decision. The review backlog for Mr O'Brien was particularly long. Others addressed theirs so Tony Glackin and Mark Haynes looked back to try to sort the issues. This was done on Patient Centre not via the notes. During that process they realised that nothing was on Patient Centre so that prompted my concern in March

minutes at that meeting, it was an informal discussion. Certainly listening to Mrs. Trouton's statement yesterday was helpful for me to recall what happened.

96 Q. Yes. Obviously, up to this point, based on what you've said this morning, you had no prior warning that Mr. O'Brien was, from the perspective of those two managers, causing difficulties. I think you said you allowed for the possibility that something might have been said informally at a meeting, but certainly the suggestion of a great problem hadn't come to your door? 10:56

A. I think that's right, that's as I recall, yeah.

97 Q. Yes. At this meeting it's been said that you would have been told about several issues, including the triage issue?

A. Mm-hmm. 10:57

98 Q. Retention of patient notes at home, and a relatively new issue, which was the alleged failure to properly, and sometimes at all, dictate following a clinical engagement with a patient. Do you agree that those issues are likely to have been raised? 10:57

A. Yes. Yes.

99 Q. What were Mr. Mackle and Mrs. Trouton looking from you?

A. I think they wanted advice. Part of it was a listening ear, because they had obviously been struggling with this problem for quite a while and they wanted a fresh -- 10:57

100 Q. Did they tell you that?

A. I believe so, yeah. It's obviously difficult without having minutes of the meeting, but as I recall. They

wanted a fresh pair of eyes looking at the situation. It certainly struck me, and we discussed that this matter had been clearly attempted to be managed very informally and with workarounds for a long period of time, and it was time now to deal with this in a more deliberate and intentional manner to bring it to a conclusion. I certainly didn't feel that there had been a clear line of direction given to Mr. O'Brien as to what needed to be done, or that the concerns were of a significant nature in recent times. We discussed possible options and I think we agreed it was still worth a chance to resolve these matters relatively straightforwardly by putting down a clear marker of what was expected of him and giving him the opportunity to resolve those issues in the first instance. 10:58 10:59 10:59

101 Q. Presumably the approach Mr. Mackle coming to you was entirely appropriate?

A. Yes. Oh, yes, yes. I mean, strictly speaking, the lines -- Mr. Mackle would have had the opportunity to come to me at any time with an issue like that. Usually, Mrs. Trouton would have gone through her line manager, which would have been Mrs. Gishkori, but I always made it clear if there were issues of professional nature that were a concern to any member of staff, they could approach me directly and I was happy to see them. But it was a little unusual to have the Associate Medical Director and the Assistant Director come to me with an issue of this nature, that was unusual but appropriate, I think. 10:59 11:00

I don't think I ever mentioned MHPS specifically, but I was in no doubt that we weren't going to let this sit indefinitely, and I don't think they were either.

109 Q. The plan or the advice that you offered them, can you help us with that? 11:11

A. I felt that there had been a lack of clarity for Mr. O'Brien as to what was expected of him. I think also the fact that there had been so many workarounds may have led him to believe that some of his behaviour was acceptable. I couldn't see any evidence that that 11:12 had been laid out clearly for him. I suggested that they met with him and wrote to him, outlining the issues that were concerning them, and indicating that he had to address them within a reasonable time frame. After that, we would see what happened. I don't think 11:12 I discussed in detail, but there was an implicit assumption that had he required any -- you know, had he come back with a plan, that there would have been support to try and help him achieve it if that was required. I think both Mr. Mackle and Mrs. Trouton 11:12 suggested that that would be the case. I did think, and others may judge me wrong, but I thought it was better to ask him for his way of resolving this, because of this history of kickback, the more direct instructions that you give him, it might have been he 11:13 could have kicked back to any one of those. I wanted the instruction to be clear about the issues that had to be dealt with but to leave it over to him as to how he resolved those, because he may have had his own

9.2 Decisions would be taken jointly by Mrs Toal, myself, and the relevant Service Director. Mr Gibson was present as support but not in a decision-making role.

9.3 I am not entirely clear what is meant by the 'medical staffing manager'. This is not a term that I would use. Mrs Siobhan Hynds was appointed Senior Human Resources Manager to support the investigation administratively.

9.4 Mrs Martina Corrigan was the Head of Service. She would have been asked to provide information or context to the Oversight Team's deliberations and to the Case Manager regarding Mr O'Brien's compliance with this return to work plan

Handling of Concerns relating to Mr O'Brien

10. In respect of concerns raised regarding Mr Aidan O'Brien:

I. When did you first become aware that there were concerns in relation to the performance of Mr O'Brien?

II. If different, also state when you became aware that there would be an investigation into matters concerning the performance of Mr O'Brien?

III. Who communicated these matters to you and in what terms?

IV. Upon receiving this information what action did you take?

I, II, III & IV

10.1 Mrs Trouton (Assistant Director for Surgery) mentioned that there were difficulties with Mr O'Brien triaging patients and other administration issues at a meeting in January 2016. As indicated in my statement in response to Section 21 Notice No. 27 of 2022, I do not recall the detail of this meeting but I understand that we agreed that she should write to Mr O'Brien describing her concerns and asking him to amend his practice in line with that of his colleague Urological Surgeons. This meeting was informal and not minuted.

10.2 As far as I can recall the next discussion I had regarding this issue was with Mr Haynes (Initially Clinical Director, then Associate Medical Director) in September 2016 when he became AMD for Surgery, in which he shared that an

same, and I did not make any decisions regarding same during my tenure as Assistant Director.

10. I have now, in light of the subject matter of this section 21 notice, appraised myself as to both the MHPS Policy and the Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance 2010. Both refer solely to the responsibilities and role of the clinical manager in the use of these documents. As there is no defined role for the operational manager, I can only assume that is why I was not aware of these documents and why training was not provided for operational managers like me in this policy and guidelines.

11. Following the emerging concern relating to the lack of clinic outcomes recorded on Patient Centre in 2015 as I recall, and following verification of this concern by Mrs. Martina Corrigan, (then) Head of Service for Urology and ENT, advice was sought by Mr. Mackle, Associate Medical Director, and myself from Dr Richard Wright, Medical Director, as to the best next steps in addressing our concerns with Mr. O'Brien. As I recall, it was the notification of another concern regarding Mr. O'Brien's administrative practice that prompted a request for a direct meeting with the Medical Director. I also alerted my Operational Director, Mrs. Esther Gishkori, of this latest concern and I have a note of a one to one meeting with Mrs. Gishkori which records same. This is located in *Relevant to PIT, Evidence received after 4 November 2021, Reference 77, Reference 77 - Heather Trouton, 2015 esther*

12. To the best of my recollection a meeting with Dr Wright took place on 11th January 2016. I have no written record of the meeting with Mr. Mackle and Dr Wright, however, I clearly remember that it took place in the Associate Medical Director's office on the Administration Floor of Craigavon Hospital. The date is noted in my witness statement to Dr Chada and Siobhan Hynds as part of the MHPS investigation held in 2017 *Appendix 22 - Amended Witness Statement - Mrs H Trouton 050617 (Bates number: TRU-00799- TRU-00802).* Following discussion of all the concerns regarding Mr. O'Brien's administrative practices, and all the actions that hitherto had been taken to try to address same and in particular the latest concerns re clinic outcome recording, Dr Wright advised Mr.

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. Untriaged outpatient referral letters

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. Current Review Backlog up to 29 February 2016

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. Patient Centre letters and recorded outcomes from Clinics

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: 028 3861 2025

patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. Patient Notes at home

This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,

_____	_____
Eamon Mackle	**Heather Trouton**
Associate Medical Director	**Assistant Director**

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by the USI

(iv) Patient notes at home

9.16 I can confirm that this had been an ongoing issue for years and, in respect of my tenure from 2013. There was no electronic system to capture the extent of this performance issue. To clarify: we could run a report from Patient Administrative System which gave us the location of a chart, for example, in a clinic, in an office or on a ward. But a problem arose if the chart was removed and not 'casenote tracked' because there was then there no way of knowing where the chart was. However, with Mr O'Brien, if he didn't bring the chart back and it was tracked to him at a clinic, his office, his secretaries office or the ward, and it was not to be found in the relevant one of those places, then on most occasions when he was asked for it he did have it and he then brought it in from home. So, whilst we could not quantify how many charts were at his home, we were able to verify that this was a well-known practice of Mr O'Brien's to take patient notes home with him and not return them.

VI. How did Mr O'Brien respond to being informed of the concerns and when presented with the letter?

9.17 I can confirm that I accompanied Mr Mackle to the meeting on 30 March 2016 with Mr O'Brien. The meeting took place in the Associate Medical Director's office on the Admin Floor of Craigavon Area Hospital. I can confirm that my recollection of the meeting is that it was not a confrontational meeting in that both Mr Mackle and Mr O'Brien were courteous to each other. Mr Mackle started it by thanking Mr O'Brien for taking the time out of his busy schedule to meet with us and they both talked for a few minutes about the busyness of the hospital in general. Then Mr Mackle explained the purpose of the meeting and gave Mr O'Brien the letter and went through the content with him. Mr Mackle advised him that, if he had any queries, we were happy to talk this through with him there and then or, if he wanted time to consider the content and come back to us, then we were happy to meet with him

again. Mr Mackle advised him that we would need an action plan to address the four issues and both Mr Mackle and I offered him support with any of the content and asked if there was anything we could do to assist him. My recollection is that Mr O'Brien took the letter, folded it up and put it in the inside pocket of his jacket and told us that he would need time to consider the content. My recollection is that, once Mr Mackle had finished discussing the letter, Mr O'Brien's manner was a subdued one and he left immediately after Mr Mackle had finished going through the content.

VII. What action was Mr O'Brien to take in respect of the matters referred to at the meeting and in the letter, and was a time-frame for compliance specified to him?

9.18 I can confirm that Mr Mackle drew Mr O'Brien's attention to the final paragraph of the letter, namely, that he needed to respond with an immediate plan to address the four concerns in the letter. Mr O'Brien advised us that he needed time to consider the content and my recollection is that Mr Mackle advised him that he needed to come back with a plan within 4 weeks and I do not recall if Mr O'Brien agreed to this at the time.

VIII. What, if any, support or assistance was offered to Mr O'Brien to ensure that he was enabled to comply with the stipulated actions?

9.19 Both Mr Mackle and I offered support to Mr O'Brien in addressing the actions to comply with the concerns raised in the letter. I also told Mr O'Brien that I would be happy to help him if needed and, if he wished, that I could see if I could get help from the rest of the team if required. Mr O'Brien acknowledged this but never took me up on the offer. And, on reflection, I admit that I didn't approach him after the meeting to see if he still required any help.

that version.

A. The final version?

114 Q. Yes.

A. No, definitely not.

115 Q. We don't have to go to it, it's just for the Panel's note, TRA-02256. So in your mind, this was the last time you had anything to do with the correspondence? 11:16

A. Absolutely.

116 Q. Except for updating the information?

A. Yes. 11:16

117 Q. Now that letter, even though you had updated the information on the 30th March, the version given to Mr. O'Brien was dated the 23rd March?

A. Yes.

118 Q. And you had nothing to do with that either, I presume, had you? 11:16

A. No. No, I didn't.

119 Q. You met with Mr. O'Brien on the 30th March with Mr. Mackle?

A. I did, yes. 11:16

120 Q. Now in relation to that meeting, did you keep a note of that?

A. I didn't. It was actually a very short meeting. I don't even think it lasted 10 minutes. It was whilst both Mr. O'Brien and Mr. Mackle were very courteous to 11:16 each other and talked about the business of the hospital just generally, the meeting was very short and succinct and I think it was just we gave him the letter, Mr. Mackle just gave the headings, he didn't

read the letter in detail. I do recall Mr. O'Brien folded up the letter and asked: "What am I going to do with this?" And I can't recall whether it was myself or Mr. Mackle but I definitely know that we said we had four weeks, we needed a response. Now I do know from reading -- from information in preparation for this that there was a -- Mr. Mackle is supposed to have shrugged his shoulders and rolled his eyes. I honestly can't say if that happened or not, but I could have just been looking at Mr. O'Brien at the time. And I did offer Mr. O'Brien, as I would have always done, if you need any help give me a -- my phrase is, as you can see from e-mails, "give me a shout". 11:17 11:17

121 Q. Just to deal with the shrug issue, that's a contention of Mr. O'Brien's where, when he was asked about what's expected, he was met with shrug of the shoulder and he says that at AOB-1367. That's not your recollection? 11:18

A. No.

122 Q. So going back to your recollection, that's the first time that it had been written in a formal way, the letter to Mr. O'Brien, about issues that had sought to be addressed, at least informally by you over the years? 11:18

A. That I'm of aware, yes.

123 Q. Now the Panel have seen the letter. I don't need to go to it but I don't think it is contentious to say that there's no mention of a plan or timeframes or specific actions that were expected from Mr. O'Brien? 11:18

A. That's correct.

relation to it?

A. There was an e-mail from Simon Gibson I know, but I can't remember if Simon Gibson spoke to me at that stage about maybe about six months later.

199 Q. Mr. O'Brien recalls that at the meeting he asked you what should be done to address the situation which you were particularising for him, and his recollection is that you shrugged your shoulders and didn't provide any indication that support would be available to help him navigate these issues? 12:26 12:27

A. I would have been very careful of my body language for that meeting. I would not have just been shrugging my shoulders if I had been asked.

200 Q. Mm-hmm. Have you a recollection of how long the meeting lasted? 12:27

A. It was a short meeting if I remember right, but I can't tell you exactly how short.

201 Q. Did he engage on the issues?

A. There was no discussion from him to explain why any one issue was an issue. As I recall, he took the letter, I read the bullet points, he took the letter and then basically folded it up and put it in his pocket. I think, I think he may have said something like he'd consider it, but I can't recall exactly what he said at the end. But he did not go through the letter in any detail or offer any explanation. 12:27 12:28

202 Q. Yes. So apart from you saying that he would consider it, is there anything else you can offer the Inquiry in terms of his response to it? We know what you have

Could I put to you Mr. Mackle's perspective and see what, if any, difference there is between you? When he gave evidence - and I'll refer here to the transcript reference, I don't need to bring it up, I can summarise it - the transcript reference is 002265. He says that 10:06
he would have been careful with his body language. He wouldn't have been shrugging his shoulders. He would have read the bullet points from the letter. It was a short meeting. You took the letter, folded it, put it in your pocket, said you would consider it. And 10:07
Mr. Mackle doesn't recall offering any support and nor does he recall being asked for any support.

Is there much between you in terms of how the meeting developed, based on that summary? 10:07

A. I think there's a significant point. The meeting is etched on my memory. I have a very clear and unambiguous recall of it. It was conducted in a very well-mannered, courteous and professional manner.
I went to that meeting. We didn't sit down. Eamonn 10:07
and I stood facing one another. Martina was seated on a seat with her back to the window. And Eamonn explained to me that he wanted to share some concerns that they had and he felt that it was better and kinder to deliver those concerns to me in person rather than 10:08
sending them through the post. So, he went about -- there were four concerns, and he said 1, 2, 3, and then he couldn't remember the fourth one. He opened the envelope and he read the fourth one, and he handed it

to me. And I scanned down through it. And at the end of that I said to him: 'What am I to do?' And he -- I mean I know Eamonn's body language. He just went like that (indicating). As he shrugs his shoulder, he tends to have a facial movement as well. That's what he did. The only words that Martina spoke was to explain that she was the there in place of Heather Trouton who couldn't attend that day, for whatever reason. And I looked at it again, and I left. 10:09

4 Q. Your question, again, to him was what am I to do with this? 10:09

A. Yes, what am I to do? What do you want me to do. Words to that effect. A simply singular question like that. What am I to do? What am I supposed to do? And he shrugged his shoulders. 10:09

5 Q. If we just go to the bottom of the letter please, it's two, perhaps three pages on. Yes, thank you. The letter was explicitly clear about what you were to do?

A. Yes, it was to respond with a commitment and an immediate plan to address the above as soon as possible. 10:10

6 Q. While he may have shrugged his shoulders, that was the answer to the question, wasn't it? That's what you were to do?

A. Yes. 10:10

7 Q. Was your question meant in a different way?

A. In what regard?

8 Q. Was your question a request for assistance?

A. No, it was --

9 Q. Help? Support? Or was it --
A. -- advice as to what I was to do. How am I going to tackle this? No support or advice was given. I think I was looking for advice in the first instance. How do I go about doing this? And I remember clearly walking up the stairs to the second floor to my own office and sitting there and reading it and thinking, how am I going to tackle this mountain, particularly a review backlog, with those sort of numbers? And the only way that I could consider doing it was just to do more. Certainly, with regard to the review backlog, if you compare the waiting list figures for reviews as of March '16 and compare them with early December '16 when an update was done, I had taken 294 patients off the back end of that review backlog, which extended back into 2013. But, unfortunately, during the course of those months I had added another 220 as a consequence of possibly reviewing reviews or discharges or whatever. And I did all of the additional operating that you demonstrated yesterday. 10:11 10:11 10:12 10:12

10 Q. We will look at some of those explanations of what else was going on at that time. But it doesn't seem explicitly clear from what you've just said that you were asking him for support or assistance. But you went away and thought about it and the questions that came into your head was, how am I going to do this, 10:12
A. Mmm.

11 Q. And just so we're clear, Mrs. Corrigan has said that in her discussions with Mr. Carroll, I think it's in an

email to Mr. Carroll on 28th April - the reference is TRU-274671 - that the expectation was that they were to get a response from you in four weeks?

A. I have read that.

12 Q. Is that your understanding of what you were to do? 10:13

A. No.

13 Q. How did you read the letter when it asked you to provide an immediate plan? Was it less than four weeks or --

A. I didn't interpret this at all as me having to reply with a written plan to anyone. And I -- that was my -- it was never my interpretation that I had to reply with a plan. To me a response can be inclusive, indeed, of a reply which, to my mind wasn't explicitly specified in this letter. I wasn't asked to reply with a plan. 10:13 10:14 But I responded with all of the actions. That was my interpretation of it. And it was -- if there was any doubt about that, when you ask what are you supposed to do, that seemed to me to -- I never even considered that I had to reply with a plan to anyone. It was to 10:14 respond with a commitment and an immediate plan to address the above as soon as possible. That's what I did to the best of my ability.

14 Q. The language of this, respond with a commitment and immediate plan didn't speak to you of communicating 10:15 a response to what was asked of you?

A. It did not.

15 Q. Thank you. So, in terms of four weeks, you had to come back to us within four weeks. Can you recall that

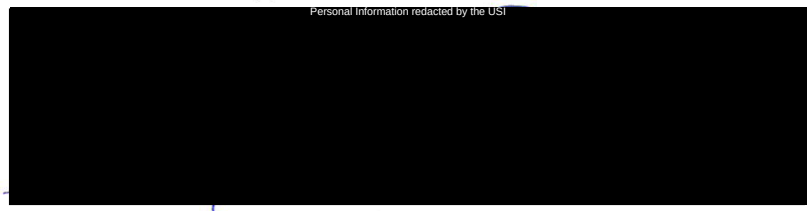
being said?
A. I certainly do not recall it because it wasn't said. I didn't know of that until I read it in that email.
16 Q. When you took it to your office and you read it and thought about it, did you speak to anybody about it? 10:15
A. No. I just was too demoralised, so despondent, demoralised.
17 Q. Did you speak to friends/family about it?
A. I didn't even speak to my family about it.
18 Q. One response might have been, after you had thought about it and calmed down, would have been to go back to Mrs. Corrigan. We understand your difficulties with Mr. Mackle, but to say, 'listen, you handed me this yesterday or last week and I've been thinking about it. I'm going to need some assistance to work through some of these issues.' 10:16
A. In retrospect that might have been -- my response might have been better to have included that kind of step but I didn't do it. I felt that I was being left on my own to try to cope with these concerns. 10:16
19 Q. We'll work through the concerns. If you go back to the top of the letter. Scroll down to Issue 1 then. At that point it is recorded at 253 untriaged letters dating back to December '14. You've reflected already in your evidence that the impossibility, from your perspective, of doing triage was something that you thought was already in the mix, was already known? 10:17
A. Yes.
20 Q. I think you called to mind the meeting, I think you

Whilst I will strenuously and robustly address the concerns enumerated in your letter of formal notification, when provided with the opportunity to do so, I must make clear at this stage that I do not accept, as stated in your letter, that the Trust attempted to address the issues regarding administrative practices, informally or at all. I was invited to meet with Mr. Eamon Mackle and with Mrs. Martina Corrigan on, or after, 23 March 2016 when I was advised of the Trust's concerns, and provided with the letter dated 23 March 2016. There was no enquiry made as to the causes of the concerns. There was no offer of a discussion of how the concerns could be resolved, or of any assistance in doing so. When I asked what I should do to address and resolve the concerns, my request was met with silence and a shrug of the shoulders. There was no follow up to the meeting, or to the letter of 23rd March 2016.

I am anxious to return to work. I am particularly concerned for the welfare of those patients awaiting excessively long periods for admission for surgery, and whose outcomes are being further jeopardised by further delay, and for those patients whose review has been further delayed during this period of exclusion.

You will appreciate that this whole process has been profoundly traumatic, stressful and distressing for me and for my family. The fact that the only communication that I have received from the Trust to date has been your letter of formal notification, has only further exacerbated that stress. It is also inevitable that this is causing me reputational and financial loss and damage, particularly as you advised me to desist from private practice whilst the investigation is conducted. Moreover, the welfare of patients is causing me further concern. Accordingly, I trust that you will address the issues raised in this letter as a matter of urgency.

Yours sincerely,



Aidan O'Brien.

Gibson, Simon

From: Gibson, Simon
Sent: 18 August 2016 09:50
To: Corrigan, Martina
Cc: Wright, Richard
Subject: CONFIDENTIAL - Dr A O'Brien

Dear Martina

Richard has briefed me on the above, and asked that I commence a discreet piece of work on issues of concern and actions taken to date.

Could you forward any relevant information you have on file, and we can meet for an initial discussion next week.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI

Gibson, Simon

From: Trouton, Heather
Sent: 22 August 2016 17:10
To: Gibson, Simon; Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan
Subject: RE: Confidential - AOB

Simon

I have had no correspondence from Mr O'Brien with regard to any proposal or plans to address the issues referred to in this letter since the 23rd March 2016.

Heather

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI

1.2 Pertaining to this Inquiry I was appointed as Associate Medical Director (AMD) for Surgery in April 2016 in addition to being AMD for ATICS (Anaesthetics, Theatre, Intensive Care and Chronic Pain, some 38 Consultants and Staff-grades). I ceased being AMD for Surgery by October 2016.

1.3 As Surgical AMD my role was to be the interface between the Director of Acute Services, their assistant (Assistant Director), the Medical Director, his assistant (Assistant Director) and the two Clinical Directors in Surgery, Lead Clinicians for the various sub-specialties, the Consultants and Staff-grades, of which there were approximately 39. This was in addition to a full clinical commitment to anaesthesia, Intensive care (ICU) and a one in five night and weekend ICU on-call including evening ward rounds at 21.00.

1.4 Aside from my clinical duties as Surgical AMD I had to attend regular meetings; monthly Morbidity and Mortality Meeting (4 hours), monthly Clinical Governance Meeting (1 Hour), monthly AMD/CD Meeting with the Medical Director (3+ hours), monthly Theatre Users Group (Chairman) Meeting (3 hours), quarterly Drugs and Therapeutics Committee Meeting (3 hours each), weekly one to one meeting with the Surgical Clinical Directors, monthly meeting with the Director of Acute Services/Assistant Director, Monthly meeting with the Medical Director (frequently cancelled) and sundry other meetings the details of which I cannot recall.

1.5 Issues that were raised with me were shared/escalated to the AD Surgery who then escalated to the Director of Acute Services, or shared/escalated directly by me to the Director of Acute Services or the Medical Director or both as seemed appropriate from who I took advice and instruction.

1.6 I have listed below the issues that were presented to me in the email sent to Ronan Carroll (AD), Esther Gishkori (Director) and the Medical Director (Dr. Richard Wright) on the 9th May 2016 at 15.41 (S21 No 32 of 2022 Attachments, 20160509 email re problems from RC). I have no memory of any meetings or discussions related to issues listed in that email other than those pertaining to Urology/Mr. O'Brien. I have

UROLOGY SERVICES INQUIRY

USI Ref: Notice 22 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Colin Weir

I, Colin Weir, will say as follows:-

[1] Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1. I was appointed Consultant in General Surgery to Craigavon Area Hospital Group Trust (later Southern Health and Social Care Trust) in August 1996.

2. I have held several senior roles including Associate Medical Director for Education and Training until 31/7/2018, and Foundation Programme Director until 31/7/2017.

3. I was appointed Clinical Director ('CD') in surgery after competitive interview starting 1/6/2016 and ending 31/1/2022. For clarity, my area of responsibility initially (until December 2018) was urology, ENT, and general surgery in Daisy Hill Hospital. After December 2018, when I returned from a period of sick leave my area of responsibility was switched to General Surgery on the Craigavon

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 5 of 2022

Date of Notice: 30th March 2022

Witness Statement of: Ronan Carroll

I, Ronan Carroll, will say as follows:-

[1] Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1. The Southern Trust came into existence in April 2007. I was appointed as Assistant Director for Cancer & Clinical Services in April 2007 to April 2016, job description located in *S21 5 of 2022 – 20070301 doc Number 5 JD AD for CCS*. The services contained within this clinical portfolio included Cancer Services, Radiology Services, Laboratory Services, Anaesthetists, Theatres and Intensive Care (ATICS) and Allied Health Professionals (AHP)

2. In April 2016, Acute Services were restructured under the guidance of Esther Gishkori, Director of Acute Services and my Assistant Director portfolio changed to becoming Assistant Director for ATICS and Surgery and Elective Care (SEC). As AD the responsibility for ATICS continued on as it had been between 2007 and 2016. I now had the additional responsibility for the operational management of SEC. SEC included the following surgical services General Surgery, Urology, Ear Nose and Throat (ENT), Trauma and Orthopaedics (T&O), Ophthalmology and Outpatients. The Surgical services were delivered across three hospital sites; Craigavon, Daisy Hill and South Tyrone Hospital with Outpatient services delivered over five sites; Craigavon, Daisy Hill, South Tyrone, Armagh and Banbridge Hospitals.

IX. Following the issuing of the letter, was an action plan to deal with the concerns ever received from Mr O'Brien and if not, were further requests made for its production requested?

9.20 I can confirm that, to the best of my knowledge, Mr O'Brien didn't provide an action plan to deal with these concerns to either Mrs Trouton or Mr Mackle and I can confirm that I was never provided with an action plan from Mr O'Brien.

9.21 I can confirm that I didn't make any further requests to Mr O'Brien for an action plan and, to the best of my knowledge, there were no further requests by any other managers (although this can be definitively confirmed by them).

9.22 In April 2016, due to the Director of Acute Services, Mrs Gishkori, reorganising her structure, Mr Carroll replaced Mrs Trouton as Assistant Director and Mr Mackle resigned from his post of Associate Medical Director. As Mr O'Brien had been issued with the 23 March 2016 letter on 30 March 2016 at our meeting, it is my opinion that this change in personnel meant that the letter of March 2016 was not followed up as it should have been. On reflection, this was a failing on my part and on the part of others, including those who replaced Mrs Trouton and Mr Mackle.

9.23 As part of Mr Carroll's handover, I sent him an email on 28 April 2016 updating him on (amongst other issues) the letter that had been given to Mr O'Brien on 30 March 2016. In this email I advised him that, whilst we had no Associate Medical Director or Clinical Director in post, the Medical Director (Dr Wright) was aware of the issues. I also advised Mr Carroll that Mr O'Brien had been asked to respond within four weeks and that as of the date of the email there had been nothing received.

Corrigan, Martina

From: Corrigan, Martina
Sent: 28 April 2016 16:25
To: Carroll, Ronan
Subject: FW: Confidential letter to AOB - updated March 2016
Attachments: Confidential letter to AOB - updated March 2016.docx; Actions from AMD and Mr Suresh Meeting; Actions from AMD and Urology Consultant Meeting

Ronan,

Conscious that we are currently without an AMD and a CD in our division and there were a few issues that were been taken forward by Eamon and I want to make sure that they are not forgotten about. The Medical Director is aware of these.

Attached is joint letter from Eamon and Heather to Aidan. Eamon and I met with him and on 30 March 2016 and discussed the issues and gave him the letter, we were to get a response in 4 weeks (nothing as of yet).

There is also an on-going issue with Ram Suresh and I will update you about this when we next see each other, again Eamon and I have been taking this forward and I attach some emails regarding this, again now that we have no AMD and CD, this still needs to be actioned, because yet again he is oncall this week and no formal cover.

There is also the issue of Job Plans. Mark Haynes has firstly been trying to get his job plan put on Zicardian since he started 2 yrs ago (11 May 2014). It has now been put on and he is waiting for sign-off and there was to be a meeting with Eamon to get this signed off. He is constantly asking me about it as he needs it sorted – again not sure how to progress?

Happy to discuss further but wanted to make sure so that you are aware of these.

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 15 June 2016 14:48
To: Weir, Colin
Subject: FW: Confidential letter to AOB - updated March 2016
Attachments: Confidential letter to AOB - updated March 2016.docx

Hi Colin

As discussed!

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by USI
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI

Stinson, Emma M

From: Carroll, Ronan [redacted]
Sent: 09 May 2016 22:37
To: McAllister, Charlie
Subject: RE: Problems

Importance: High

I think it is safe to say you have a good handle on things
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 09 May 2016 15:41
To: Carroll, Ronan; Gishkori, Esther; Wright, Richard
Subject: Problems

Dear All

Since being asked to take over responsibility for Surgery as AMD I have been trying to get my head around as many of the issues as possible. To date:

1. There is no real functioning structure for dealing with governance. Mr Reddy is the Gov laed for surgery so is supposed to attend weekly meetings with AD and HOS to review IR1s that have come in, however the AD routinely missed the meeting (Before RC) so no actions tended to come from them.
2. There were supposed to be monthly meetings with the clinical leads, AD, HoS and AMD to discuss issues but attendees poor at keeping the date so frequently cancelled.
3. FY1 rota issues. Not enough so non-compliant.
4. Paeds interface very poor and not resolved.
5. Largely each specialty left to manage themselves, reliance on HoS to escalate issues.
6. Urology. Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home and questions being asked re inappropriate prioritisation onto NHS of patients seen privately.
7. Not enough CAH lists so very inefficient extended days (not enough beds to service these) and spare theatre capacity in DHH with underutilised nursing and anaesthetic capacity.
8. Middle grade cover is scant so unable to provide a urology rota at night thus gen surgery regs cover this. G Surg regs occasionally have to help with urology elective lists.
9. ENT – not enough theatre time so extended lists – with problems as per urology. Problem with junior doc rotas.
10. Ortho. Job plans still not agreed.
11. SOW handover – variable – some consultants don't attend – but is in job plan as far as I know.
12. NIMDAT middle grade allocation – never get our full allocation on either site. Becoming increasingly difficult to find suitable locums to fill gaps. Likely to hit the point in the next year to 18 months where running two acute middle grade rotas isn't feasible. DHH rota particularly shaky.
13. If junior doc numbers particularly low then build up a backlog in dictation and results – governance risk.
14. I am not aware that sign-off of results is secure. Governance risk.
15. Colorectal issue – dysfunctional relationship between CAH and DHH. Possibly agenda to collapse DHH in order to have two Surgical rotas on the CAH site – one colorectal and one for everything else.
16. Interface between gastroenterology and GI surgeons.
17. Breast service teetering. Radiology support precarious.
18. Significant backlog of IR1s/SAIs. Governance risk.

Corrigan, Martina

From: Corrigan, Martina
Sent: 17 August 2016 17:07
To: Wright, Richard
Subject: RE: confidential

Hi Richard,

See updated position below:

1. Untriaged outpatient referral letters

There are currently 174 untriaged letters dating back to May 2016

2. Current Review Backlog up to 31 July 2016

Total in Review backlog = 679

2014	243
2015	244
2016	180

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Wright, Richard
Sent: 09 August 2016 09:21
To: Corrigan, Martina
Subject: confidential

Hi Martina. Did we ever make progress with regard to the issues raised re Urology which Eamon had been dealing with? Regards Richard

Corrigan, Martina

From: Corrigan, Martina
Sent: 18 August 2016 13:57
To: Gibson, Simon
Subject: RE: CONFIDENTIAL - Dr A O'Brien
Attachments: RE: confidential; RE: confidential

Hi Simon,

As discussed, please see attached information that I had forwarded to Richard and we can catch up on Monday PM to discuss in detail

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: Gibson, Simon
Sent: 18 August 2016 09:50
To: Corrigan, Martina
Cc: Wright, Richard
Subject: CONFIDENTIAL - Dr A O'Brien

Dear Martina

Richard has briefed me on the above, and asked that I commence a discreet piece of work on issues of concern and actions taken to date.

Could you forward any relevant information you have on file, and we can meet for an initial discussion next week.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI

Gibson, Simon

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI

Gibson, Simon

From: Carroll, Ronan
Sent: 23 August 2016 14:28
To: Gibson, Simon
Cc: McAllister, Charlie
Subject: RE: Confidential - AOB

Importance: High

I have received nothing from Mr O'Brien

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: Gibson, Simon
Sent: 23 August 2016 12:22
Cc: Carroll, Ronan
Subject: RE: Confidential - AOB

Dear Ronan

Would appreciate a response to the below please.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by the USI Ext Personal Information redacted by USI

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan Personal Information redacted by USI; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

Willis, Lisa

From: McAllister, Charlie [redacted]
Sent: 22 August 2016 17:57
To: Gibson, Simon; Mackle, Eamon
Cc: Carroll, Ronan; Trouton, Heather
Subject: Re: Confidential - AOB

Dear Simon

As you know I came into this mid stream. I have received no communication from Mr O'Brien on this topic.

Charlie

Sent from my BlackBerry 10 smartphone.

From: Gibson, Simon
Sent: Monday, 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

I am asking all four of you due to the changing roles and responsibilities you have all had between 23rd March and today, as at some point you would have had responsibilities with regard to Mr O'Brien and/or the service he delivered.

I would be grateful if you could respond to this e-mail, even if you have not received any plans or proposals.

Given the sensitivity of this subject, I would be grateful if you would respect the confidentiality of this e-mail.

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
[redacted]

July I organised for general surgery trainees to assist the urologists when performing open surgery.

[51] Was the urology department offered any support for quality improvement initiatives during your tenure?

187. There was a proposal from the Urology team to introduce one-stop clinics for investigating haematuria and for investigating possible prostatic cancer. These were supported and I believe they won a Trust award for same.

Mr. O'Brien

[52] Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

188. The Medical Directorate structure was that Aidan O'Brien would liaise with his Lead Clinician, Michael Young, who in turn would report to his Clinical Director, Robin Brown, who in turn would report to me. However, any clinician was able to skip one or two stages and speak to me directly. Michael Young also attended the monthly meeting with Heather Trouton and myself. For the approximately 18 months of Monday night meetings I would have met with Aidan O'Brien for up to 90 minutes. We would have met monthly at the Morbidity and Mortality meeting and I believe this lasted about two hours. Outside of those two processes my contact would probably have been a maximum of 1% of my time. Once I was accused of bullying and asked to step back, I had very little contact with him until March 2016, when I delivered the letter to him summarising the concerns regarding him. I cannot recall having a conversation with Aidan O'Brien since March 2016.

Stinson, Emma M

From: McAllister, Charlie [redacted]
Sent: 30 August 2016 09:02
To: Weir, Colin
Subject: Re: Confidential - AOB

Thanks. V disappointing. This is not the direction of travel I wanted for many reasons.

C

Sent from my BlackBerry 10 smartphone.

From: Weir, Colin
Sent: Tuesday, 30 August 2016 09:13
To: McAllister, Charlie
Subject: Re: Confidential - AOB

OK got it

Colin Weir
From Blackberry

From: McAllister, Charlie
Sent: Tuesday, 23 August 2016 11:11
To: Weir, Colin
Subject: FW: Confidential - AOB

Strictly in confidence.

Hi Mr Weir

Please see below. This has come to light subsequent to our discussions on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two so wont get a chance to meet/discuss.

Please hold off on attempting to address this issue until the dust settles on the process below.

Thanks

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

at something, does that mean that you as an Associate Medical Director, Mr. Weir as a Clinical Director, does that mean you just can't go anywhere near it?

A. It's been a process taken on by the Medical Director and his agent. Mr. Weir was away. I was going to be away very shortly. There wasn't a lot of opportunity to get involved. 15:39

476 Q. Again, on reflection, should you have at this stage -- I know you said you were going to get away, but should you have perhaps tried to engage with Mr. O'Brien before the Medical Director gets involved and however serious that might become? 15:39

A. In hindsight, yes, that may have helped the situation temporarily, but it would have come back again.

477 Q. If we just complete the email chain by scrolling up. On 30th August 2016 Mr. Weir responds: Okay, got it. He has clearly got the message. He was off for a week, then above you say: 15:40

"Thanks. V disappointing. This is not the direction of travel I wanted for many reasons." 15:40

Could you outline what those reasons were?

A. I think we hadn't been given a chance to come up with a strategy for effectively dealing with Mr. O'Brien's issues on an ongoing basis. 15:40

478 Q. You considered the intervention from the Medical Director to mean that you'd lost that chance?

A. I thought that was likely.

479 Q. You never picked up the phone to Dr. Wright and said:

Hold on a second here, Colin and I might have a plan.

A. No.

480 Q. If you had have done that, do you think Dr. Wright would have been receptive?

A. I couldn't say. 15:41

481 Q. Could we get on the screen, please, TRU-274370? This is a slightly discrete issue this time. Sorry, it is 274730. What is coming on the screen is an email chain with regards to a patient. While the patient's name is on the screen I would be grateful if you could 15:42 refer to them as Patient 93 for the purposes of this discussion.

Scroll down to the bottom. This is an email from Mark Haynes to Martina Corrigan at this stage about Patient 15:42 93.

"The story here is raised PSA referred by GP on 4th May. GP referal is routine. Not returned from triage, so on well is routine. If had been triaged would have 15:42 been RF upgrade. PSA 34 and 30 on repeat. Saw Mr. Weir for leg pain and CT showed metastatic disease and prostate primary. Referred to us and seen yesterday. As a result of no triage delay in treatment of 3.5 months. Mr. Haynes's view is that it wouldn't 15:43 change the outcome and queried if it should be called an SAI."

Do you have any recollection?

A. I do.

would have been wrong for me to continue, you know, with my own process or our own process.

97 Q. If you just go back down -- sorry, James -- to Mr. Gibson's email:

11:07

"I have been asked by the Medical Director to consider a range of issues in relation to Mr. O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr. O'Brien to address the issues." 11:07

It does not necessarily sound as if the Medical Director is kind of, you know, about to launch into a full scale process at that stage, it simply sounds that the Medical Director is trying to gather some 11:07 information. Should this have stopped you and Dr. McAllister, really, from at least trying to engage with Mr. O'Brien, even simply just to say, listen, Aidan, the Medical Director is sort of asking questions, we need to try to sit down and sort this 11:07 out?

A. Yeah, I mean if that was the case then it would have made sense to say, right, let's just move this on to something else, the Medical Director's Office is looking into this, then -- I mean, yeah, that would 11:07 have been my issues, at least for that point, resolved.

98 Q. While I note Dr. McAllister's email to you implies you're on leave, do you recall if you did speak to Aidan O'Brien after this email or did you follow his

Gibson, Simon

From: Gibson, Simon
Sent: 05 September 2016 14:25
To: Wright, Richard
Cc: White, Laura
Subject: CONFIDENTIAL Screening Investigation - Mr A O'Brien
Attachments: Screening report.docx

Dear Richard

As requested, please find attached a screening report on Dr O'Brien.

Would you like me to convene a meeting of the Oversight Committee to consider this report?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by the USI

Southern Health & Social Care Trust

Medical Directors Office

Screening report on Dr Aidan O'Brien

Context

The Medical Director sought detailed information on a range of issues relating to the conduct and performance of Dr O'Brien. This report provides background detail and current status of these issues, and provides a recommendation for consideration of the Oversight Committee.

Issue one – Un-triaged outpatient referral letters

When a GP refers a patient into secondary care, the referral is triaged to consider the urgency of the referral. If triage does not take place within an agreed timescale as per the Integrated Elective Access Protocol (IEAP), then health records staff schedule the referral according to the priority given by the GP. This carries with it the risk that a patient may not have their referral "upgraded" by the consultant to urgent or red flag if needed, if triage is not completed. This may impact upon the outcome for a patient.

In March 2016, Dr O'Brien had 253 untriaged letters, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 174 untriaged letters, dating back 18 weeks; the rest of the urology team triage delay is 3-5 working days.

Issue two – Outpatient review backlog

Concerns have been raised that there may be patients scheduled to be seen who are considerably overdue their review appointment and could have an adverse clinical outcome due to this delay.

In March 2016, Mr O'Brien had 679 patients in his outpatient review backlog, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 667 patients in his outpatient review backlog, dating back to 2014: whilst outpatient review backlogs exist with his urological colleagues, the extent and depth of these is not as concerning.

Issue three – Patients notes at home

Mr O'Brien has had a working practice of taking charts home with him following outpatient clinics. These charts may stay at his home for some time, and may not be available for the patient attending an appointment with a different specialty, making the subsequent consultation difficult in the absence of the patients full medical history.

For a period in 2013/14, instances when charts were not available were recorded on the Southern Trusts Adverse Incident Reporting (IR) system: there were 61 consultations where charts were not available. In speaking to the Health Records Manager, Mr O'Brien is currently continuing this practice although this is not now recorded on the IR system.

Mr O'Brien was spoken to about this issue in 2012 by Dr Rankin, and twice in 2014 by Mrs Burns, the Directors of Acute Services at the time, seeking a change in behaviour, although none of these meetings were formally recorded.

Issue four – Recording outcomes of consultations and inpatient discharges

Whilst there has been no formal audit of this issue, concern has been raised by his urological colleagues that Mr O'Brien may not always record his actions or decisions regarding a patient following a period of inpatient care or outpatient consultation. This may cause subsequent investigations or follow up not to take place or be delayed.

Summary of concerns

This screening report has identified a range of concerns which may be counter to the ***General Medical Councils Good Medical Practice*** guidance of 2013, specifically paragraphs 15 (b), 19 and 20:

15. ***You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:***

- *a. Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
- *b.* ***Promptly provide or arrange suitable advice, investigations or treatment where necessary***
- *c. Refer a patient to another practitioner when this serves the patient's needs.*

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. ***You should make records at the same time as the events you are recording or as soon as possible afterwards.***

20. ***You must keep records*** *that contain personal information about patients, colleagues or others securely, and* ***in line with any data protection requirements.***

Conclusion

This report recognises that previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm.

28.2 The impression I have formed of the implementation of MHPS and Trust guidelines in relation to the Mr O'Brien case was primarily one of surprise that Mrs Gishkori decided to move away from the decision of the Oversight Committee to commence an investigation in September 2016.

28.3 I was also surprised that the formal investigation took from January 2017 to September 2018 to complete. I note from the timeline in the Case Investigators report that there were a number of lengthy delays which accounted for the length of this investigation.

28.4 A final impression I have is one of concern that the Case Managers recommendations were not implemented in a timely manner; I am aware that the Case Manager submitted his recommendation in September 2018.

29. Consider and outline the extent to which you feel you can effectively discharge your role under MHPS and the Trust Guidelines in the extant systems within the Trust and what, if anything, could be done to strengthen or enhance that role.

29.1 I had no formal role within MHPS; my role was administrative in nature in supporting the Medical Director and worked to his or her direction. Therefore, I feel I am able to effectively discharge my role within the existing systems of the Trust.

29.2 On reflection, I do recognise that the screening of concern stage of the MHPS process should have been the undertaken by the clinical manager rather than myself, and that my actions at that stage were outside the agreed guidelines. I undertook the screening of concern as the Medical Director directly asked me to, and the concerns under consideration with administrative and statistical in nature, rather than any concerns requiring clinical consideration. I felt confident in being able to summarise the issues

because we were going to put together, call an oversight meeting and we needed some background information to be able to discuss that with a view to escalating this to a more formal procedure.

163 Q. We obviously have medical managers in place. We have, by now, Mr. Weir, Mr. McAllister and the tier above him. Why is this task of scoping out the extent of the problem given to somebody in your office as opposed to a Clinical Manager? 12:12

A. Okay. The first thing is, Mr. Gibson is very senior manager with a lot of experience, and he would have done this on numerous occasions -- well several occasions for me before. He was working to me so this was, if you like, a delegated role that I asked him to do on my behalf. I wanted this done quickly. There was a sense of urgency now because I had realised that this was not working; the measures we put in place were not working, and we wanted to get on top of this as a matter of some urgency. If I had asked Mr. Weir or any of the other Clinical Directors, this would have been on top of their already incredibly busy workload, and I don't think it would have been done just as quickly. That's not to disrespect them or to make light of their abilities, but the reality is that they would have struggled to have done this in the time frame. This would have been a normal way of working for us in preparation for an oversight committee. We hadn't formally started an MHPS process at this point. This was simply background preparatory information to 12:12 12:13 12:13

that point a Serious Adverse Incident had been identified and there was concern about patient harm.

11. Once capability concerns were identified there needed to be a clear diagnosis of the issues and the scope of an investigation defined. That is a stage when the Trust might have taken some wider soundings to be clear it investigated the right issues.

12. Upon being informed of a Serious Adverse Incident and patient harm, I would expect a Medical Director, to carry out a soft investigation in relation to wider concerns around clinical capability, which would then inform the Terms of Reference of any subsequent investigation. This might be considered as another missed opportunity.

13. The categorisation of the initial concern can make a significant difference to how a case progresses, with the distinction between capacity (with options for assessment and remediation) and conduct (which can lead to a disciplinary). If Simon Gibson did not know about any clinical capability concerns in September 2016, that avenue under the MHPS Framework (detailed further below) effectively disappeared.

Failure to progress an effective investigation

14. Even when the case was thought to involve clinical issues and apparent patient harm, there was a failure to progress a timely effective investigation within the Trust. We sent three separate emails chasing progress to the Trust on 1 January, 1 March and 1 May 2017 which were not responded to and as a result the PPA case file was closed in August 2017.

15. The file closure following no response to chasing emails is standard practice. I recognise that this makes the assumption that the Trust is capable of managing the process, however it seems that very little was done in the gap between the call between Richard Wright and my (then) colleague, Grainne Lynn on 28 December 2016 (where patient harm was highlighted) and a call was received from Dr Khan on 17 September 2018.

16. Under the MHPS Framework the investigation should be undertaken within four weeks. The problem with this is that it is almost always unachievable, which results in people having lower expectations about a timely investigation. A much more realistic timetable would be 12 weeks, in order to undertake a proper exploration of all potential concerns.

17. I am familiar with the issue of an investigation getting underway and new concerns coming to light. We now train investigators to think carefully about how to deal with this and whether to modify their Terms of Reference or to start a separate investigation that need not delay or derail the first.

194 Q. Capabilities, yes.
A. Sorry. Yes. Because you mentioned capacity.
195 Q. I'm using that interchangeably. But let's stick to capability, so not to confuse you.
A. Thank you. 12:48
196 Q. He says that the circumstances that you describe to him, he seemed to suggest that they are not conduct issues but capability issues. That's not how you understood it?
A. No. 12:48
197 Q. The other issue he addresses is the need for a wider soundings to ensure that the right issues are investigated. You accept that as an operational manager, or non-clinical manager, you were probably not, at least in terms -- you were definitely not, at 12:49
least in terms of the guidelines --
A. Yes.
198 Q. -- and the MHPS process, definitely not the right man for this job.
12:49
Would you accept that a Clinical Manager might have a better sense of the problems that might exist below the surface in the practice of their colleagues?
A. Yes. Absolutely.
199 Q. At no time were you tasked with the job of taking the 12:49
investigation wider than the four items that are reflected in your screening report?
A. No.
200 Q. Do you think there was a missed opportunity to look

write to Mr O'Brien, outlining her concerns and asking him to amend his actions in line with best practice in line with that of his colleagues.

55.2. I would have met with Mr Mackle on a couple of occasions in his role as Associate Medical Director informally between July 2015 and March 2016. I do recall discussing other team surgery issues such as the safety of the service in Daisy Hill Hospital, junior doctor rotas and Staff vacancies amongst the wider surgical team but I have no specific recollections regarding discussions concerning Mr O'Brien.

55.3. Mr Haynes (Associate Medical Director) contacted me by telephone in early September 2016 to alert me of the issues subsequently addressed by the MHPS process. After that phone call I would have spoken directly to Mrs Toal (Director of Human Resources) and to Simon Gibson (Assistant Director, Medical Director's Office) to establish and arrange an Oversight Committee meeting to discuss the issues raised. I asked Simon Gibson to contact the National Clinical Assessment Service (NCAS) prior to the oversight meeting to discuss possible approaches to addressing the issues raised. The Oversight meeting was then arranged for 13th September 2016. Mrs Gishkori was invited but was unable to attend so Mr Carroll (Assistant Director) attended in her place.

55.4. Most of the discussions I had regarding Mr O'Brien are recorded in the minutes of the Oversight meetings. The relevant meetings took place on 13th September 2016, 12th October 2016, 22nd December 2016, 10th January 2017 and 26th January 2017.

55.5. In addition to this:

i. I met briefly with the Chief Executive (Mr Rice) and then the Trust Chair to update them on the MHPS process in the last week of December 2016, in particular to request that they identify a designated person from the Trust Board to oversee the process I discussed the case with NCAS on 28th December 2016 and again just before Mr O'Brien's return to work in late January 2017.

ii. I held a meeting on 30th December with Mr O'Brien, accompanied by his wife, with Human Resources Manager Lynne Hainey.

because we were going to put together, call an oversight meeting and we needed some background information to be able to discuss that with a view to escalating this to a more formal procedure.

163 Q. We obviously have medical managers in place. We have, by now, Mr. Weir, Mr. McAllister and the tier above him. Why is this task of scoping out the extent of the problem given to somebody in your office as opposed to a Clinical Manager? 12:12

A. Okay. The first thing is, Mr. Gibson is very senior manager with a lot of experience, and he would have done this on numerous occasions -- well several occasions for me before. He was working to me so this was, if you like, a delegated role that I asked him to do on my behalf. I wanted this done quickly. There was a sense of urgency now because I had realised that this was not working; the measures we put in place were not working, and we wanted to get on top of this as a matter of some urgency. If I had asked Mr. Weir or any of the other Clinical Directors, this would have been on top of their already incredibly busy workload, and I don't think it would have been done just as quickly. That's not to disrespect them or to make light of their abilities, but the reality is that they would have struggled to have done this in the time frame. This would have been a normal way of working for us in preparation for an oversight committee. We hadn't formally started an MHPS process at this point. This was simply background preparatory information to 12:12 12:13 12:13

have an informed discussion.

164 Q. The MHPS process seeks to define and designate who might be responsible for initial steps.

A. Yes.

165 Q. If I could just have your reflections on this. 12:14
WIT-18501. If we go to paragraph 15. Under the heading "informal approach", the first task it says of the clinical manager, the clinical manager is defined within an appendix in the document usually to mean a Clinical Director: 12:14

"... 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 inquiries are essential to verify or refute 12:14 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 12:15 in consultation with the Medical Director and Director of HR, taking advice from NCAS or Occupational Health where necessary."

Is it fair to say that the task described there is the 12:15 one that you have given to Mr. Gibson, or is it something different?

A. No, it's not quite the same. We were working obviously within our own Trust guidelines on an oversight

So for peer comparison within urology, for instance, that was not robust enough. Part of that would have been simply the culture within Northern Ireland medicine. There has been a lot of resistance to introducing that type of data on a systemic basis. But I have no doubt that having someone assigned with a dedicated role as a Deputy Medical Director, for instance, with that as their role would have been very helpful. That's what I was trying to achieve. I don't think that by itself would have changed the culture but it would have been very helpful. 15:59 15:59

237 Q. It takes a lot of time to do it well?

A. It takes a lot of time to make it really work. I think the colleges could have a role in this, to be honest. For example, radiology, I was a radiologist. Getting hard data on a radiologist's performance is quite difficult but the colleges are best placed on what is reasonable to expect. I think they have sort of ducked their obligations there. They've stayed back from coming out. In something like surgery where they could say 'return to theatre, complication rate, mortality. There are indicators that could -- 15:59 15:59

238 Q. There's nothing to stop the Trust doing that either though?

A. There is nothing to stop, but it is much easier to introduce if you have the colleges saying, 'this is what you should do, folks'. 16:00

239 Q. One last question. NCAS, a really important tool. Why did you delegate the task of speaking to NCAS at the

beginning to Simon Gibson, because when I was Medical Director I would always have done that myself.

A. I think there was just too much going on at that time and I knew we had to inform them quickly. It wouldn't normally have been my practice. I would have spoken to them. In fact, I can't think of any other case where I would have done that. It was simply -- and I can't remember what it was, but there are other things going on that I just couldn't make that call on that day. 16:00

240 Q. In that context you would then normally seek some sort of assurance about the support being offered, would you, in the Directorate? NCAS always say 'support them through whatever you're doing'. People don't always know what that means. It can mean lots of things. Is that built into your processes now that you actually know what they're doing to support the doctor? 16:00 16:01

A. To be really honest, I don't know what the process is now within the Trust because I have been gone for quite a few years.

241 Q. I'm really asking for your view on that? 16:01

A. It is very important. Both the doctor who is the subject of the Inquiry but also the doctors who are the -- well, any staff who are involved in being interviewed or being involved --

242 Q. Correct? 16:01

A. -- and they people conducting the investigation where these things can be quite traumatising and very difficult for them.

243 Q. Would you recommend that that's always brought back to

was first set up, I largely spoke to medical directors, chief executives, people who were very senior in the organisation, as organisations got bigger and things changed, we wound up being phoned by less senior people. Now, Simon Gibson is a very sound man but he's not very, very -- he's not senior enough to take decisions off his own bat. It is much easier to bounce these things around when you are talking to someone who can take a decision at a high level. I suppose that was one thing that was a bit of a problem. If you talk to somebody that's senior enough to actually decide, well, that's what we're going to do, it was much easier to bounce ideas around. But the sounding board thing, yes, I can accept that. That's fine. 08:57 08:57

76 Q. Would you like to see a return to that time when it was the senior decision-maker who made the call -- 08:57

A. Yes.

77 Q. -- for the good reasons you explain?

A. In a word, yes. I don't want to sound like an old fogey, talking about the old days. But yes, you got further in those days; you could take a decision. Because otherwise you are having a discussion with somebody who is going to go off, talk to a committee or somebody senior. That's an extra stage in the process which makes it more difficult. It is much easier to talk to someone who is actually senior enough to take a decision and also understands the clinical background. So, that's the advantage of talking to a clinician, they actually understand the clinical 08:58 08:58

National Clinical Assessment Service

NCAS
N I office
HSC Leadership Centre
The Beeches
12 Hampton Manor Drive
Belfast
Co Antrim
BT7 3EN

Tel: 028 90 690 791

www.ncas.nhs.uk
Personal Information redacted by the USI

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

Mr Simon Gibson
Assistant Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

NCAS ref: Personal Information redacted by the USI

Dear Mr Gibson

I am writing following our telephone discussion on 7 September. Please let me know if I have misunderstood anything as it may affect my advice.

You called to discuss a consultant urologist who has been in post for a number of years. You described a number of problems. He has a backlog of about 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog.

You said that he is very slow to triage referrals. It can take him up to 18 weeks to triage a referral, whereas the standard required is less than two days.

You told me that he often takes patient charts home and does not return them promptly. This often leads to patients arriving for outpatient appointments with no records available.

You told me that his note-taking has been reported as very poor, and on occasions there are no records of consultations.

To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology.

The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

Relevant regulations/guidance:

- Local procedures;
- General Medical Council Guide to Good Medical Practice;
- Maintaining High Professional Standards in the Modern HPSS (MHPS).

Review date:

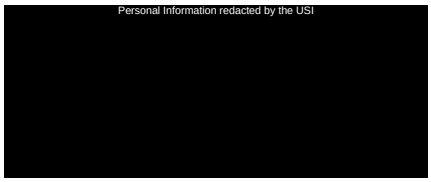
7 October 2016.

As it seems likely that further NCAS input will be required, we will keep this case file open and review the situation in about one month. If you require further advice in the meantime, please do not hesitate to contact me.

If you have any further issues to discuss, or any difficulties with these arrangements, please contact the Northern Ireland office on the direct line above.

I hope the process has been helpful to you.

Yours sincerely



Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.

Oversight Group Meeting

Tuesday, 13th September 2016 @ 10:00am in
The Chief Executive's Office, Trust Headquarters, Craigavon Area Hospital

NOTES & ACTION POINTS

Present: Dr Richard Wright
Mrs Vivienne Toal
Mrs Esther Gishkori

In attendance: Mr Simon Gibson
Mr Malcolm Clegg

Medical MHPS Cases, Doctors in Difficulty, GMC & NIMDTA Issues

Irrelevant information redacted by the USI

AOB:

The oversight group was informed that a formal letter had been sent to AOB on 23/3/16 outlining a number of concerns about his practice. He was asked to develop a plan detailing how he was intending to address these concerns, however no plan had been provided to date and the same concerns continue to exist almost 6 months later. A preliminary investigation has already taken place on paper and in view of this, the following steps were agreed;

- Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB
- The meeting with AOB should take place next week (w/c 19/9/16)
- This letter should inform AOB of the Trust's intention to proceed with an informal investigation under MHPS at this time. It should also include action plans with a 4 week timescale to address the 4 main areas of his practice that are causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges
- Esther Gishkori to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week
- AOB should be informed that a formal investigation may be commenced if sufficient progress has not been made within the 4 week period

ACTIONS:

1. **Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB next week**
2. **Esther Gishkori to meet with Colin Weir, Ronan Carroll and Simon Gibson to go through the letter and confirm actions required**

26(iii) The lack of Clinical Management input to the Oversight Group in the 2010 Trust Guidelines was problematic, and meant that the Oversight Group was driving the decision making in relation to the early actions in September 2016, as opposed to the Clinical Manager. Whilst the role of the Oversight Group as outlined in para 2.5 of the 2010 Trust Guidelines, was described as a quality assurance role, the absence of the Clinical Manager at the meetings meant that the Oversight Group determined the actions to be taken. On reflection, this resulted in an approach in September 2016, which was, in effect, contrary to Section I Para 15 MHPS, which outlines that the role 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. What happened in the Mr O'Brien case was that a non-medical Assistant Director, Simon Gibson took the lead in the Preliminary Enquiries in September 2016 in conjunction with, I assume, Acute Services' staff such as Martina Corrigan and Ronan Carroll, and presented the report at the Oversight Group meeting without the Clinical Manager, Mr Weir, Clinical Director, there. The absence of the Clinical Manager, Mr Weir also permitted a divergence from what was the agreed course of action at the Oversight Meeting on 13th September 2016 by Directors. Those agreed actions were subsequently debated outside of the meeting by the Clinical Managers, Mr Weir, Clinical Director, and Dr McAllister, Associate Medical Director, with Esther Gishkori, Director of Acute Services. As a result, the agreed actions from 13th September 2016 Oversight Group meeting subsequently changed after further discussion between Esther Gishkori, Francis Rice, Interim Chief Executive and Dr Wright, Medical Director, a number of days after. If Mr Weir, as Clinical Manager had been present in the Oversight Group meeting in September 2016 there may have been greater discussion, about not only clearing the backlogs, but also more about checking and reviewing if any of the patients in those backlogs had come to harm. I very much regret that those discussions did not happen robustly enough and there was not more focus on ensuring that work commenced urgently after the meeting on 13th September to check if the patients in the backlogs had come to any harm. This issue was further exacerbated by the fact that both Mr Weir and Dr McAllister were off Personal Information redacted by the USI

Gibson, Simon

From: Gibson, Simon
Sent: 13 September 2016 14:12
To: Gishkori, Esther; Toal, Vivienne; Clegg, Malcolm; Wright, Richard
Cc: Stinson, Emma M; White, Laura; Mallagh-Cassells, Heather
Subject: CONFIDENTIAL - Letter to AO'B - first draft
Attachments: Letter to AOB - 1st draft 13-9-16.docx

Dear all

Draft of letter for comments back please.

Esther – I phoned Martina with regard to what is a realistic yet challenging target with regard to the outpatient review backlog. Her view was 229 in the month of October (19 additional clinics) would not be achievable, and we don't want to set him a target we know he can't reach, and then penalise him. So, we have gone with 70 per month, every month, until end of December. Operationally, this is your call, but just wanted you to be aware of the thought processes behind the target chosen

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Southern Health & Social Care Trust
Personal Information redacted by USI
Mobile: Personal Information redacted by USI
DHH: Personal Information redacted by USI

Southern Health and Social Care Trust

Draft letter

21st September 2016

Dear Mr O'Brien

Formal notification of investigation under Maintaining High Professional Standards (MHPS)

I am writing to inform you of the Southern Trusts intention to proceed with an investigation under MHPS with regard to a range of issues in relation to your practice. At this stage, we will be taking an informal approach as outlined within MHPS, but following the outcome of this we may proceed with a formal investigation.

This investigation should be seen in the context of the letter written to you on 23rd March (copy attached), in which a number of concerns were raised and a plan was sought from you to address these concerns. No plan was provided and the same concerns still exist.

This informal approach will consider four areas of your practice, and be time bound as indicated below.

Area 1 – Untriaged letters

In August 2016, you had 174 untriaged outpatient referral letters, dating back 18 weeks. It is the expectation of the Trust that by the time you commence your next Urologist of the Week session, on 21st October, this backlog is eliminated. Furthermore, it is the expectation of the Trust that at the end of your week as Urologist of the Week, you are completing the triage of outpatient referral letters within the Trust standard of 72 hours.

Area 2 - Outpatient review backlog

As at 31st August 2016, you had 658 patients on your outpatient review backlog, including 229 going back to 2014. It is the expectation of the Trust that this 2014 backlog is reduced to zero by the end of the calendar year, with a reduction of a minimum of 70 patients per month.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI / Email: Personal Information redacted by USI

Area 3 – Patients notes at home

I am aware that you have had a practice of taking notes home with you, and this has been discussed with you previously, yet this practice has continued. It is the expectation of the Trust that all hospital notes at your house are returned to Martina Corrigan, Head of Service for Urology, within 24 hours of the date on this letter.

There are to be no exceptions to this.

Once these charts are returned, they will be recorded and their location tracked on PAS either back to filing, your office or your secretarys office, in line with Trust procedures.

Area 4 - Recording outcomes of consultations and inpatient discharges

It has been brought to my attention that on occasion you might not make contemporaneous notes following an outpatient consultation or inpatient discharge. It is the Southern Trusts expectation that, from the date on this letter, you make contemporaneous notes to ensure that your colleagues are aware of the clinical management plans for any patient.

A clinical note review will be undertaken of 20 sets of notes seen by yourself in the four weeks following the date on this letter, to assess your compliance with this expectation.

In late October, an assessment will be made on your progress towards the targets in these four areas of practice, as outlined above. Should the Southern Trust conclude that sufficient progress has not been made, or other issues are identified during the four week period of assessment, then a formal investigation will be commenced under the terms of MHPS.

I very much appreciate that investigations can be particularly stressful and I therefore wish to advise you that the services of Carecall (0808 800 0002) are open to you throughout the course of the investigation to provide help and support.

Under MHPS, it is intended that the Investigation Team will conclude their investigation by 31st October; however, you will be kept informed if this is not achievable.

Yours sincerely

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI / Email: Personal Information redacted by USI

Committee meeting on 13th of September. We went through the decisions that were made at that meeting, and you explained to us that you weren't brave enough to challenge the decision reached at that Oversight meeting, and you had reservations about it. You were concerned that the plan that was developed at that meeting had no real involvement for Mr. O'Brien. You were concerned that he might walk away, leaving the service with a backlog which he was best placed to clear, in your view. You thought it might be better to have direct intervention from his colleagues such as Mr. Weir and Dr. McAllister, and you wanted to review the position and speak to them. 09:40 09:41

We also dealt with your conversation with, I think you recalled it as Dr. McAllister and Mr. Weir on 14th September? 09:41

A. I know that I spoke to Mr. Weir at a point in time, but on that day I think it was just Ronan Carroll and Mr. McAllister. 09:41

3 Q. Yes.

A. Because that would have been -- normally Ronan Carroll was my AD for Surgery and Anaesthetics.

4 Q. Yes.

A. So that would have been my choice. And I do believe, having read some of the papers here, that it was Ronan, and I do believe it was the two of them. 09:42

5 Q. Yes.

A. Ronan was easily accessible, if you know what I mean.

Toal, Vivienne

From: Wright, Richard [redacted]
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther [redacted] wrote:

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.
>
> I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.
>
> Happy to discuss any time and I will of course brief the oversight committee of any progress we make.
>
> Many thanks
> Best
> Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
[redacted]

Toal, Vivienne

From: Clegg, Malcolm [redacted]
Sent: 16 September 2016 09:02
To: Toal, Vivienne
Subject: RE: meeting re Mr O'Brien.

Yes of course Vivienne.

I'll send a draft to you in case I have missed anything important.

Malcolm

From: Toal, Vivienne
Sent: 16 September 2016 08:58
To: Clegg, Malcolm
Subject: FW: meeting re Mr O'Brien.

Malcolm

See below….

Is there any chance that you could type the notes of the oversight meeting up….we are definitely going to need notes going forward particularly if goalposts keep trying to be changed.

Vivienne

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
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> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.

Stinson, Emma M

From: Gishkori, Esther <[redacted]>
Sent: 14 September 2016 13:17
To: McAllister, Charlie
Subject: FW: Confidential - AOB
Attachments: Confidential letter to AOB - updated March 2016 final.docx

Thanks Charlie.
At least you have a starting point.
I am clear that I wish you and Colin to take this forward and explore the options and potential solutions before anyone else gets involved.
We owe this to a well respected and competent colleague.
I can confirm that you will have communication in relation to this before the end of the week.
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] **Mobile** [redacted]
[redacted]

From: McAllister, Charlie
Sent: 14 September 2016 12:25
To: Gishkori, Esther
Subject: FW: Confidential - AOB

Hi Esther

Further to our meeting today here is the only communication that I have received on this subject.

Regards

Charlie

From: Gibson, Simon
Sent: 22 August 2016 15:54
To: Mackle, Eamon; McAllister, Charlie
Cc: Carroll, Ronan; Trouton, Heather
Subject: Confidential - AOB

Dear all

I have been asked by the Medical Director to consider a range of issues in relation to Mr O'Brien. As part of this, I would be grateful if each of you could confirm back to me if you have received any plans or proposals from Mr O'Brien to address the issues outlined in the attached letter.

A. Yes.
687 Q. You thought that was going to be a more efficacious and more likely to be fruitful in delivering a solution?
A. I honestly did. I honestly believed in my heart, you know, it made sense. 16:58
688 Q. Was any part of the thinking around this 'Mr. O'Brien and his reputation, and we need to protect him from adverse publicity, perhaps, associated with an MHPS investigation'? Was that part of what was driving this? 16:58
A. I wouldn't say protect him, no. I wouldn't have protected anybody where there was Patient Safety issues. I suppose it would have been a win -- the way I was looking at it, and bearing in mind I didn't know Mr. O'Brien from Adam. I didn't know the man at all, 16:59
but everybody else had told me, even in somebody Neta Chada's report, the patients loved him, everybody thought he was great. He set up the Service himself. He was part of -- he set the Service up. So I'm thinking, well -- and he also was a viable part of the 16:59
team, albeit in Theatre all day long. But, however, he was still very much needed and, don't forget, Urology was in an absolute dire straits in Northern Ireland. Mark Haynes one of our consultants had to go to Belfast on a Friday. Just so -- so all that was in my mind. 16:59
689 Q. Did you have a fear that if the informal MHPS group was adopted that Mr. O'Brien would walk away?
A. I did. I did. I honestly did.
690 Q. And that would impact the Service.

there is maybe some confusion over the formality. I think there was a level of formality there by putting the concerns on paper.

164 Q. Yes. So, by contrast to what we know had now taken place in previous years of ad hoc communication with Mr. O'Brien to ask him to improve or do certain things, this was putting a degree of formality around a request for the plan on the four issues that had been raised? 12:42

A. Yes.

165 Q. But you're not suggesting, and as far as you're aware, this Minute isn't to be taken as suggestion that you or the organisation with Mr. O'Brien was within, kind of, any formal structure or system or process? 12:42

A. That's right.

166 Q. I'm obliged. Thank you. Now, the next step following the production of this letter which went to Mrs. Gishkori on 13 September was that she engaged with Dr. McAllister and Mr. Carroll to consider an alternative, as it transpired, to what Oversight had produced? 12:42 12:43

A. I think it was Dr. McAllister maybe, not Mr. Carroll, Dr. McAllister, is that what you mean?

167 Q. Well, I'll put it again. What I meant to say was that Mrs. Gishkori, on 14 September, met with Dr. McAllister -- 12:43

A. Yes.

168 Q. And we understand that Mr. Carroll was in attendance.

A. Yes. I think so, yes, apologies.

169 Q. And Mr. Weir may or may not have been. We're not

terribly sure about that, as the evidence stands. But just on that issue, can you remember hearing that an alternative plan was afoot?

A. So Esther, I think it was on the 16th, 15th? I can't remember. So the Oversight was on the 13th. I think then there were discussions on the 14th, and maybe it was the 15th. So there is an email there that basically Esther --

170 Q. Let me pull it out?

A. Yes, if you can clarify the date. 12:44

171 Q. TRU-263681. At the bottom of the page.

A. The 15th.

172 Q. You can see that Esther is writing to you:

"Further to our Oversight Committee, two days earlier, I had a meeting with Charlie and Ronan. I mentioned the case that was brought to the Oversight meeting in relation to Mr. O'Brien and the Plan of Action." 12:44

A. Yes.

173 Q. "Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr. O'Brien's performance was of course part of that." 12:45

Moving over the page please:

12:45

"Now they both work locally with him. They have plenty of ideas to try out and since they are both relevantly new into post I would like to try their strategy first. I am, therefore, respectfully requesting that the Local

Team be given three more calendar months to resolve the issues raised in relation to Mr. O'Brien's performance.

I appreciate you highlighting the fact that this long-running issue has not yet been resolved. However, given the trust and respect that Mr. O'Brien has won over the years, not to mention his life-long commitment to the Urology Service which he built up single-handedly, I would like to give my new Team the chance to resolve this in context and for good. This, I feel, would be the best outcome all round."

Do you remember what your response to it was, at least internally?

A. I think I was a bit taken aback by it. I probably was concerned that it seemed to be shifting. You know, I did send a letter or an email to Malcolm Clegg. So Malcolm would have been covering for Zoe Parks at this stage. Zoe was Head of medical staffing and she was on Personal Information redacted by the USI leave. So I did sent an email to Malcolm to type up the notes and I referenced something about there appears to be, you know, the goalposts are shifting or changing.

174 Q. Yes. I think you said to him we're definitely going to need notes going forward, especially if goalposts keep trying to be changed.

A. Yes.

175 Q. Can I ask, were notes not routinely kept of these meetings at that time?

A. Yes. Yes. They would have been kept. I suppose I was looking for them sooner rather than later, in fairness.

176 Q. In terms then of what Mrs. Gishkori is saying, she is suggesting that her local managers have a better idea of how to deal with this effectively. She's also putting into the mix a sense that Mr. O'Brien deserves different treatment or perhaps better treatment in light of his considerable background within the organisation. So let's unpack that. 12:47

12:48

We started our conversation this morning, perhaps, by reflecting that it should; thinking on this knowledge of this as better coming from the Service itself, from Clinical Managers on the ground, so is Mrs. Gishkori to be faulted for taking it in this direction? 12:48

A. I think it was the fact that it was taking place outside of it. You know, when I look at, you know, what happened afterwards and, you know, why there was maybe a change in plan, the only thing I can really link this back to was the fact that the terminology of MHPS was being used. 12:49

And I think, you know, from what I'm trying to piece together and what I'm trying to build up by way of a picture, it was the fact that this would have been put to Mr. O'Brien as MHPS and maybe his reaction at that stage and, potentially, the impact from a service point of view I think was probably in the mix. And seeing MHPS as that almost punitive approach as opposed 12:49

to really what it should be, which is around assisting a clinician in terms of bringing their practice back on line or conduct or whatever. So I think it's that view that MHPS just would have been that nuclear option, as such, and the impact and the reaction that might have had.

177 Q. You don't seem concerned clinicians are, Clinical Managers are at least having some input through Mrs. Gishkori's initiative which, as we reflected earlier, not quite in this way but it was their role to have an input having regard to the guidelines. 12:50

A. Absolutely. It's not, I don't necessarily have a difficulty, clearly, in her taking the views of her clinicians. I think it would have been much more helpful if she had done that beforehand, you know, having those discussions before she came down. I think that would have been helpful. 12:51

Actually, when you reflect on what we were asking to be done so that Simon, yes, he would draft the letter, but there needed to be a discussion amongst themselves in terms of: Right, what does this letter need to say? What way are we handling this? So it was very much making sure that operationally that the leaders within the Acute Services Directorate had an involvement. I'm just not sure that we ever anticipated then that the plan would change in the way that it did and the way that Esther then emailed Dr. Wright and I afterwards. 12:51 12:51

178 Q. Of course, if this had been handled in a manner in

keeping would the process, if they had come to the Oversight Committee saying: This is what we know about Mr. O'Brien and this is our plan, the Quality Assurance Role of the Oversight Group would have been able to say, hold on a minute, your plan is too weak or it doesn't deal with matters in quite the way that is needed having regard to, for example, the longevity of the issues or Patient Safety issues? 12:52

A. Yeah, and I reflected that I think in my statement. Yes. 12:52

179 Q. At that time, what was the sense of Patient Safety issues and was the Oversight Group as sensitive to those risks as it needed to have been?

A. No. We weren't as sensitive as we should have been. I think, actually Esther's paragraph there, around, you know, this lifelong commitment, built-up single-handedly, this narrative around him being an excellent surgeon, an excellent clinician, that was the prevailing sort of form at that stage. It probably desensitised us to the risks from an administrative point of view. It was as if they were two separate things and they shouldn't have been. 12:53 12:53

180 Q. I know that, you know, we will maybe come on to your reflections later, but I think we can have a snapshot of that now, I think there's a sense in your reflections that this prevailing narrative about his excellence as a surgeon created a form of a blind spot to more urgent and more effective action. Is that fair? 12:53

Stinson, Emma M

From: Carroll, Ronan <[redacted]>
Sent: 22 September 2016 15:41
To: McAllister, Charlie; Gishkori, Esther; Weir, Colin
Subject: RE: meeting re Mr O'Brien.

Importance: High

Charlie/Colin
So can I ask and offer some suggestions/solutions as to how we may monitor progress against the action listed below. The clock is ticking now toward December
Come back to me if you wish me to action anything/all

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien – At the first meeting obviously after the context of the meeting being explained the proposed plan/actions need to be shared with AOB and agreed
2. To implement a clear plan to clear triage backlog. – is this the outpatient referral letters, including RF's? How are you planning to monitor that this is cleared? I would propose with regard to the RF's that I would ask the cancer team to monitor the triage turnaround, with regard to outpatients I would ask Anita to put a process in place to monitor
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this – RBL validation – are we offering additional Pas for this to be done? If not, then something in his job plan will have to stop for this clinical validation to happen. Then when this task has been completed the remaining on the RBL can only be dealt by as your suggestion the template being adjusted, this has a lead in time of 6 weeks due to partial booking process. When this is implemented we will monitor the progress of AOBs RBL (I can have this run at anytime)
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation – I will speak to Anita to ensure AOBs secretary receives digital dictation following any consultation
5. All patient notes to be return from home without exception NA
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed absolutely
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. [redacted] this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Corrigan, Martina

From: McAllister, Charlie [redacted]
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. [redacted] this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer [redacted]

14.7 As a result of this decision, the draft letter was not sent. Dr Wright did seek to clarify the next steps in his email to Mrs Gishkori:

"Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period. Perhaps when we have seen these we could meet again to consider."

14.8 I have no record or recollection of such a plan being received by Dr Wright from Mrs Gishkori in relation to the provision of this plan

15. Outline the circumstances and the process by which you understand concerns in relation to Mr O'Brien came to be discussed by the Oversight Group on 13th September 2016 and address the following:
a. From what source did the concerns and information discussed at that meeting emanate?

15.1 My understanding is that on 9th August 2016 (Appendix 7 Email Confidential This document is attached as an Appendix to this statement) *Relevant document can be located at S21 No 46 of 2022 Attachments, 12. 20160608 Email attachment.* Dr Wright wrote to Martina Corrigan seeking an update on concerns relating to Mr O'Brien. I was not copied into this email, but the response that Martina Corrigan provided to Dr Wright was the basis for Dr Wright approaching me to request that I gather the facts into a screening report. As requested, I gathered the quantitative facts which emanated from this email correspondence in relation to Mr O'Brien's performance and compiled these into a screening report under the categories of:

a) Untriaged outpatient referral letters
b) Outpatient review backlog
c) Patients notes at home

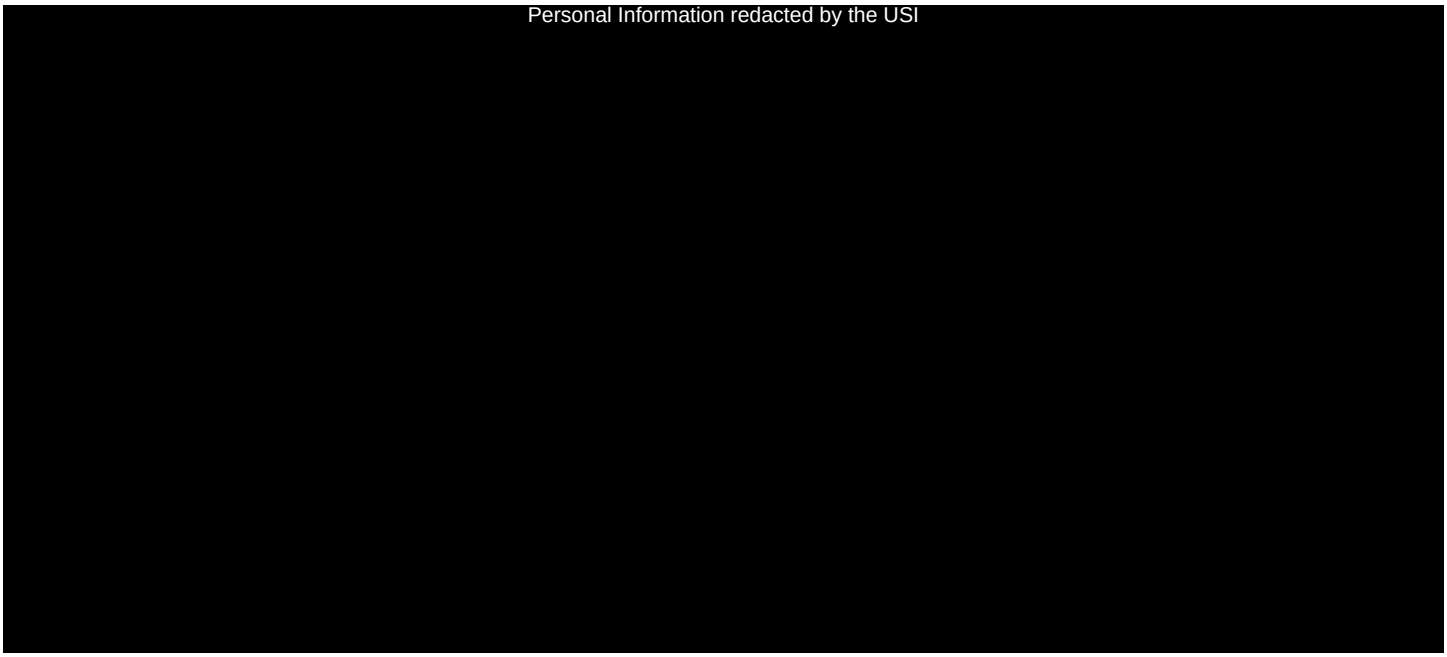
Southern Health & Social Care Trust

Oversight Committee
12th October 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, DAS

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager

Discussion:



Mr A O'Brien
Mrs Gishkori reported that Mr O'Brien [redacted] was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of [redacted] leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

Urologist of the Week, and my other colleagues and I were requested by Management to provide backup support during his week on call. I was providing that support. Mr Suresh confirmed to me that he was returning to a post in England in October 2016 and it was at that point that I decided that I could [redacted] 17th November 2016.

On 14th November 2016, I received an email from Ms Martina Corrigan, Head of Service, which is attached at Tab 16. The email related to a request for a chart that had been tracked out to me. I provided the chart that was requested. I also relayed to Ms Corrigan the following at 4.09pm on 14th November 2016:

> "Martina,
>
> [redacted] I expect to be home again over the weekend.
>
> I expect that I will be well enough to dictate correspondence concerning patients and have charts delivered to Noleen's office for typing.
>
> I would greatly appreciate if I could be afforded this opportunity to have all charts returned in this manner,
>
> Thank you,
>
> Aidan"

The "Noleen" referred to is my secretary, Ms Noleen Elliot. Ms Corrigan responded to this email 5.49pm on 14th November 2016, stating:

> "Aidan,
>
> I am more than happy with this plan, please let me know if there is anything I can do to assist.
>
> By any chance could {PATIENT CHART NAME & NUMBER} be left in as I have had governance looking for this chart as well.
>
> Wishing you all the best for Thursday, please take care
>
> Talk soon
>
> Kind Regards
>
> Martina"

I also confirmed that I had returned the chart whose name and number I have redacted. I left work the following day [redacted] I had spent the previous months between March 2016 and November 2016 trying to clear the review backlog, particularly as it related to cancer patients, in addition to all of my other commitments in 2016. I was doing so without support from management. I made the

Subject: RE: MR O'BRIEN AND CHARTS AT HOME
From: O'Brien, Aidan [redacted]
To: Corrigan, Martina [redacted]
Sent: 14/11/2016 21:32:12

Martina,

I have already asked Noleen to return [redacted] chart to Pamela Lawson, who has requested it.

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 14 November 2016 17:49
To: O'Brien, Aidan
Subject: RE: MR O'BRIEN AND CHARTS AT HOME

Aidan

I am more than happy with this plan, please let me know if there is anything I can do to assist.

By any chance could [redacted] be left in as I have had governance looking for this chart as well.

Wishing you all the best for Thursday, please take care

Talk soon

Kind regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by USI
Mobile : Personal Information redacted by USI

From: O'Brien, Aidan
Sent: 14 November 2016 16:09
To: Corrigan, Martina
Subject: RE: MR O'BRIEN AND CHARTS AT HOME

Martina,

Personal Information redacted by the USI I expect to be home again over the weekend.

I expect that I will be well enough to dictate correspondence concerning patients and have the charts delivered to Noleen's office for typing.

I would greatly appreciate if I could be afforded this opportunity to have all charts returned in this manner.

Thank you,

Aidan.

From: Corrigan, Martina
Sent: 14 November 2016 07:15
To: O'Brien, Aidan
Subject: FW: MR O'BRIEN AND CHARTS AT HOME

Further emails Aidan.

Thanks