Leicestershire Partnership NHS Trust

Managing Concerns about Medical Staff

The purpose of this policy is to outline in the context of the nationally agreed framework “Maintaining High Professional Standards in the NHS”, how a concern about medical staff may arise, how this might be managed and who might be involved.

Key Words:	Medical, Appraisal, Revalidation, Concerns, Conduct, Capability, Ill Health, Performance, Appeals, Remediation, Re-Skilling, Rehabilitation	
Version:	3	
Approved by:	Strategic Workforce Group	
Ratified by:	People and Culture Committee/SWG	
Date this version was Ratified:	March 2024	
Please state if there is a reason for not publishing on website	n/a	
Review date:	December 2026	
Expiry date:	July 2027	
Type of Policy		Non Clinical √

Contents

Quick Look Summary

1.1 The purpose of this policy is to outline, in the context of the nationally agreed framework “Maintaining High Professional Standards in the NHS” (MHPS), how a concern about medical staff may arise, how this might be managed, who might be involved and how any remedial work will be carried out.

1.2 This policy aims to provide a clear set of procedures which can be referred to when concerns arise about medical staff. The purpose is to support the delivery of a transparent and fair approach to the management of concerns of medical employees, how to approach remediation and to ensure that patient safety is the paramount consideration.

1.3 This policy applies to all doctors (referred to as “practitioners”) employed by the Trust to include substantive Consultants, Associate Specialists, Specialist Grade Doctors, Specialty Doctors, NHS locums, doctors on other locally employed contracts and those on honorary contracts.

1.4 For doctors in training, on approved training programmes, the Trust and NHS England – Midlands Workforce, Training and Education (WT&E) Directorate will seek to ensure co-operation and agreement in the management and support of issues relating to the conduct, capability or health of a practitioner.

1.5 For doctors engaged through a locum agency, the Trust should work with the locum agency and Responsible Officer to ensure concerns are appropriately managed.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

1.1 Version Control and Summary of Changes

Version number	Date	Comments
1.0	24/08/17	First publication
2.0	21/04/21	Policy review and update
3.0	14/02/24	Policy review and update

1.2 Key individuals involved in developing and consulting on the document

Name	Designation
Accountable Director	Dr Bhanu Chadalavada, Medical Director
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Core policy reviewer group	Deputy Medical Directors, Associate Medical Directors, Director of Medical Education, Clinical Directors, Claire Taylor, Head of Operational HR
Wider consultation	Medical Local Negotiating Committee (LNC) Policy expert group

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Strategic Workforce Group	People and Culture Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 3) of this policy.

1.5 Definitions that apply to this Policy

ARCP	Annual Review of Competence Progression - Process of assessment for junior doctors in approved medical training programmes.
Concerns about practice	Any aspects of a practitioner's practice, performance, conduct or behaviour which may: • pose a threat to patient safety or public protection. • expose services to financial or other substantial risk. • undermine the reputation or efficiency of services in some significant way. • be outside acceptable professional or working practice guidelines and standards.
Low level (Green) concern	Concerns where there has been no harm to patients or staff and the doctor is not vulnerable or at any personal risk. Organisational or professional reputation is also not at stake, but the concern needs to be addressed by discussion with the practitioner. This may include one of following; clinical incidents, complaints, poor. outcome data which usually requires discussion and perhaps action.
Medium level (Amber) concern	Concerns where there is a potential for serious harm to patients, staff or the doctor is at personal risk. Organisational or professional reputation may also be at stake. This may be a low-level situation plus whistle blowing and requires definite discussion and an action plan.
High level (Red) concern	Patients, staff or the doctor have been harmed. This will be a medium level situation plus a serious untoward incident or complaint requiring a formal investigation. This includes criminal. acts and referrals to the GMC.
GMC	General Medical Council
HEEM	Health Education East Midlands
NHS Resolution	Formally the National Clinical Assessment Service - NCAS. An advisory body that works to resolve concerns about the practice of doctors by providing case management services to healthcare organisations and individual practitioners.
PDP	Personal Development Plan
Practitioner	Doctors are referred to throughout this document as 'practitioners'.
RO	Responsible Officer
SAS	Specialty Doctors, Associate Specialists and Specialist Doctors.

2.0. Purpose and Introduction

2.1 Leicestershire Partnership NHS Trust is committed to ensuring patient safety through the provision and maintenance of excellent clinical care. Afundamental part of this commitment relates to how concerns are handled. The intention outlined in this document is to:

- Protect patients.
- Support the continuing professional development of practitioners.
- Promote excellence in medical practice.

- Create a learning culture where practitioners receive personal development to encourage review of their practice, work in an open and accountable manner and develop continuously.
- Maintain the Trust's duty of care to all staff.

2.2 This policy supports legislation for the revalidation of doctors. Revalidation is a process by which doctors demonstrate to the General Medical Council (GMC), normally every five years, through local clinical governance and appraisal processes that they are up to date, fit to practice and complying with the relevant professional standards.

2.3 A concern about a doctor's practice can be said to have arisen where the behaviour of the doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes or appears to behave persistently in amanner inconsistent with the standards described in the GMC's Good Medical Practice. Whilst minor concerns may be addressed through normal continuing professional development processes, this document is primarily concerned with responding to those instances where normal continuing professional development processes are not sufficient to address the concern. Further information about defining the level/seriousness of a concern can be found in Appendix 6.

3.0 Policy requirements

3.1 In order to comply with Maintaining High Professional Standards in the NHS (HSC 2003/12) (MHPS), the Trust has put in place this policy and procedure. This policy and its procedures must be read in conjunction with the relevant section of the MHPS guidance which is available at the following link:

National guidance and standards - NHS Resolution

4.0 Duties within the Organisation

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2 The Strategic Workforce Group has responsibility for this policy as the Trust Level 2 Committee.

4.3 The Medical Director / Revalidation Responsible Officer (RO) is accountable for the clinical governance systems in the organisation. It is a statutory duty of the Responsible Officer to investigate, monitor and respond to concerns about a doctor's practice. He/she is also responsible for ensuring that any follow up action is taken and that comprehensive records are maintained. The Medical Director will act as the Case Manager in MHPS investigations or delegate this role to a senior manager to oversee, and appoint a Case Investigator.

4.4 Clinical Directors, Directors and Heads of Service are responsible for clinical governance and performance monitoring systems. They have a role in escalating serious issues to the Medical Director. They also have a role in providing a supportive environment which allows practitioners to be remediated without putting patients, the public or the doctor at risk. They will be responsible for implementing any remediation programmes and monitoring its outcome.

4.5 All doctors are responsible for ensuring that they are up to date and fit to practice

according to the GMC's Good Medical Practice standards. All doctors have a responsibility to raise genuine concerns with their Line Manager. All doctors should ensure they are familiar with this policy and that they follow it when necessary.

4.6 A Non-Executive Director known as the Designated Member, is appointed at the point of exclusion or from when a formal investigation of a serious concern commences.

4.7 The Case Manager overseas an investigation and ensures it proceeds in a timely manner. The Case Manager determines the terms of reference for the investigation and also makes the decision as to the appropriate course of actionfollowing the completion of the investigation.

4.8 The Case Investigator undertakes the investigation into concerns with a representative from Human Resources and presents findings to the Case Manager

4.9 The Director of Medical Education should be informed of any concerns relatedto practitioners in training grades and will inform the Postgraduate Dean who is the "Responsible Officer" for trainees of any concerns. Concerns about the capability of doctors in training should be considered initially as training issues.

4.10 The HR Advisory Team will provide advice, supportand guidance to managers and employees on the application of this policy and the process to be followed.

5.0 Our Leadership Behaviours

The Trust has developed a leadership behaviours framework to set the standardsof expectation we aspire to in our daily work. Meeting these standards and developing the capability to exceed them, will not only ensure that we continue toimprove and respond flexibly to changing needs as an organisation, but will alsohelp our staff to fulfil their potential, both in terms of personal achievement and career advancement. Our leadership behaviours also promote compassionate conversations, respect, and positive working relationships to enable us to support the wellbeing of our workforce, particularly following serious incidents.

The behaviour framework includes:

6.0 Part 1 of MHPS - Action when a concern arises

6.1 A doctor's performance can be affected by a complex range of issues (Appendix 5). Medical managers should ensure there is clear understanding of the nature and range of concerns. Appendix 6 provides a generic framework to establish the level of a concern and ensure consistency in response and management.

6.2 Preliminary Investigation / Screening Process

A preliminary investigation may be required as a screening process to determine if concerns are of a sufficiently serious nature to warrant a full MHPS formal investigation. The screening process should have time set aside to progress so that it can be completed properly and quickly. The objective is to determine whether an investigation would be likely to produce information whichis not already available, not to begin the investigation process itself. There will normally need to be input from the practitioner.

6.3 The Case Manager or appropriate person should have a preliminary meeting with the practitioner to explain the situation and what might happen next. The practitioner's initial comments can be taken into account and their response will be helpful in deciding whether to carry out a formal MHPS investigation.

6.4 Formal investigation should be judged unnecessary where:

6.4.1 The reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;

- There are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious.

Even where there is evidence of concern, the decision may still be todispense with investigation under the following circumstances:

6.4.2 The practitioner may agree that the concerns are well-founded and agree to co-operate with required further action. However, if the issues are serious enough to suggest that if upheld they might warrant disciplinary action or referral to the GMC, then a formal investigation will commence.

6.4.3 Confirmed or suspected ill-health could mean that a formal performance investigation would be inappropriate. However, health problems may be part of a more complex presentation where investigation could be helpful.

6.4.4 An investigation may also be judged unnecessary if the concerns are being investigated by another agency. An external investigation does not automatically preclude an NHS investigation but there would need to beclear reasons for carrying out a separate investigation of the same concern.

6.5 The decision to proceed or not proceed with a formal MHPS investigation should be documented, with reasons, along with decisions on any alternative actions decided upon.

6.6 Formal MHPS Investigation

Investigation will usually be appropriate where case information gathered in the process suggests that the practitioner may:

6.6.1 Pose a threat or potential threat to patient safety;

6.6.2 Expose services to financial or other substantial risk;

6.6.3 Undermine the reputation or efficiency of services in some significant way;

6.6.4 Work outside acceptable practice guideline and standards.

6.7 In deciding to go ahead, the decision makers should have a clear view on the areas of performance that are a concern – what is to be included and what is to be excluded.

6.8 The Medical Director is responsible for the overall management of serious concerns regarding practitioners. If he/she considers, in light of evidence from the sources outlined above that the concern is serious, then the following steps will be taken:

6.9 **Appoint a Case Manager and Case Investigator** - The Medical Director may act as the Case Manager in cases involving Consultants but may delegate this role to a Deputy/Associate Medical Director or Clinical Director as appropriate, taking into account the profile and details of a particular case. The Medical Director or nominated deputy is responsible for appointing a Case Investigator. When a Case Investigator is appointed, the terms of reference for the investigation must be determined by the Case Manager, usually in conjunction with the designated HR lead

6.10 Once appointed the Case Investigator will, with support from HR:

6.10.1 Formally involve a senior member of medical staff where a question of clinical judgement is raised if the Case Investigator is not appropriately qualified/experienced to undertake this role.

6.10.2 Ensure that there are sufficient written statements to establish the facts of the case and ensure that oral evidence is given sufficient weight.

6.10.3 Produce a written report following investigation detailing the conclusions reached.

6.10.4 Where appropriate, assist the designated board member to review the progress of the case.

6.11 It is a requirement of this procedure that a practitioner will be informed in writing by the Case Manager as soon as it is decided that a formal investigation is to be undertaken. This must include:

6.11.1 the name of the Case Investigator(s)

6.11.2 the specific allegations or concerns that have been raised

6.11.3 a list of people that the Case Investigator will interview

6.11.4 that there will be an opportunity for the practitioner to put their view ofevents to the Case Investigator and the opportunity to be accompanied.

6.12 People raising concerns about professional colleagues may feel vulnerable, particularly if still working with the practitioner concerned. Where people / witnesses ask to provide information anonymously, the investigator needs to balance the rights of the practitioner under investigation and the need to collect evidence. The important factor is for the practitioner to know the detailof the concern, any evidence against them and the case they have to answer. If the matter should proceed to a conduct or capability hearing all documentation is usually available to all parties.

6.13 If during the course of an investigation it transpires that the case involves more complex clinical issues than first anticipated, the Case Manager should consider whether an independent practitioner from another NHS body should be invited to assist.

6.14 Where concerns relate to capability, the Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced. These must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments.

6.15 The Case Investigator should usually complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further five days. The Case Manager will make a decision whether:

6.15.1 There is a case of misconduct that should be put to a conduct panel and to follow the Trust's Disciplinary Procedure

6.15.2 There are concerns about the clinician's health which should be managed under the Trust's Management of Ill Health policy

6.15.3 There are concerns about performance, which should be referred to NHS Resolution - formally the National Clinical Assessment Service (NCAS)

6.15.4 Restrictions on practice or exclusion from work be considered

6.15.5 Serious matters be referred to the GMC or GDC

6.15.6 Intractable problems be referred to a capability panel

6.15.7 No further action is required.

6.16 In the event that new issues arise during the course of the investigation, the Case Investigator will:

6.16.1 Inform the Case Manager in writing of the nature of the new issues that have arisen and supply the supporting evidence.

6.16.2 The Case Manager, in conjunction with the designated HR lead will decide whether to amend the terms of reference to cover the new issues of concern.

6.16.3 In the event that the terms of reference are to be varied, the Practitioner will be provided with the amended terms of reference, together with an explanation of why the terms were varied.

7.0 Involving NHS Resolution

7.1 At any stage of the handling of a case consideration should be given to the involvement of NHS Resolution. The Case Manager, once the nature of the concern is identified, must assess the seriousness of the issue, seeking advice from NHS Resolution where necessary. A decision will then be taken whether a formal investigation is required.

7.2 NHS Resolution can be contacted via:
Website: https://resolution.nhs.uk/services/practitioner-performance-advice/advice/
Telephone - 020 7811 2600
Email - advice@resolution.nhs.uk

8.0 Confidentiality

8.1 The Trust will maintain confidentiality and the information provided externally (for example to the media) will be restricted only to confirming that an investigation or disciplinary hearing is under way or responding factually to the detail that the media hold.

8.2 The practitioner should be reminded that as a Trust employee they are bound by the terms and conditions of their contract to observe the Trust's policy on 'confidentiality' with regard to an investigation and that correspondence and discussions should remain confidential and should only be shared with their representative.

9.0 Support and Right to be Accompanied

9.1 Trust based support should be offered to the practitioner, for example through Occupational Health and AMICA, as well as informing them of their right to seek support and representation through their trade union or defence organisation. A range of support sources are listed in Appendix 7.

9.2 Any practitioner covered by this policy and procedure may be accompanied by a trade union/defence organisation representative or work colleague. Or alternatively, by a friend, partner/spouse. The representative may be legally qualified, but they will not be acting in a legal capacity. This means it is impermissible for a lawyer, either a solicitor or a barrister, to advice as a "friend"on any kind of remunerated basis.

10.0 Part II of MHPS – Restriction of Practice & Exclusion from Work

10.1 When serious concerns are raised about a practitioner, the Medical Director will urgently consider whether it is necessary to place temporary restrictions on their practice.

10.2 If there is evidence that concerns are related to the practitioner's health, the Occupational Health Department should become involved at an early stage (see Part V of MHPS).

10.3 Exclusion of practitioners from the workplace is a temporary expedient. It is a precautionary measure and not a disciplinary sanction, reserved for specific circumstances. Alternatives to exclusion must always be considered in the first instance. Exclusion is only potentially justified where:

- There has been a critical incident where serious allegations have been made; or
- There has been a breakdown in relationships between a colleague and therest of the team; or
- The presence of the practitioner is likely to hinder the formal investigation.

10.4 Before reaching the decision to exclude, it is important to seek the assistance from NHS Resolution.

10.5 Where exclusion is required, the process outlined in Part II of MHPS must be adhered

to. Part II gives guidance on the following:

- Immediate exclusion – maximum of 2 weeks
- Formal exclusion
- Keeping exclusions under review
- Returning to work following exclusion.

11.0 Part III of MHPS – Conduct Procedure

11.1 All issues regarding the misconduct of medical practitioners will be dealt with under the Trust's Disciplinary Policy and Procedure.

11.2 Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the Case Investigator must obtain independent professional advice.

11.3 Concerns about the conduct of practitioners in training grades should be considered initially as training issues and managed by the Educational Supervisor with support from the Director of Medical Education. The Postgraduate Dean should be informed from the outset.

11.4 Allegations of criminal acts should follow the guidance set out in MHPS Part III.

12.0 Part IV of MHPS – Procedure for dealing with issues of Capability

12.1 The general principles are as set out in Part IV, paragraphs 1-12 of MHPS.

12.2 If the concerns relate to the capability of an individual practitioner, these should be dealt with under this procedure whether arising from a one-off or series of incidents.

12.3 Wherever possible, issues of capability shall be resolved through ongoing assessment, retraining and support. If the concerns cannot be resolved routinely by management, NHS Resolution must be contacted for support and guidance **before** the matter can be referred to a capability panel.

12.4 Any concerns relating to the capability of practitioners in training grades must be discussed with the relevant Educational Supervisor and the Director of Medical Education, plus with the Postgraduate Dean from the outset.

13.0 Examples of Capability

13.1 The following are examples of matters which the Trust may regard as being concerns about capability (this is a non-exhaustive list):

- Out of date or incompetent clinical practice
- Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk
- Inability to communicate effectively;
- Inappropriate delegation of clinical responsibility;
- Inadequate supervision of delegated clinical tasks; and
- Ineffective clinical team working skills.

13.2 In the event that the capability issue has arisen due to the practitioner's ill health, then the Trust's Management of Ill Health Policy and the Ill Health Procedure in Part V of MHPS must be considered.

13.3 In the event of an overlap between issues of conduct and capability, then usually both matters will be heard under the capability procedure. In exceptional circumstances, it may be necessary for issues to be considered under separate procedures. The decision as to which procedure shall be initiated shall be takenby the Case Manager in consultation with the Director of Human Resources andNHS Resolution.

14.0 Consideration of the Investigation Report

14.1 Following submission of the report, the Case Manager shall decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of NHS Resolution, where appropriate. The Case Manager will need to consider urgently whether action under Part II of the procedure is necessary to exclude the practitioner; or to place temporary restrictions on their clinical duties.

14.2 The Case Manager will need to consider, taking advice where necessary,whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to NHS Resolution for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. If NHS Resolution consider that a practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan hasa realistic chance of success, the Case Manager may decide that the case should be determined under the capability hearing through a panel hearing. If apractitioner does not agree to the case being referred to NHS Resolution, a panel hearing will normally be necessary.

14.3 The Case Manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments.

15.0 Capability Hearings

15.1 **Time Limits -** Time limits for invitation to a hearing and exchange of documentsare all set out in Part IV, section 17 of MHPS.

15.2 **Panel Members -** The panel for the capability hearing shall consist of at least three people including:

- An Executive Director of the Trust (acting as Chair)
- A medical practitioner not employed by the Trust
- A Board Member or Senior Manager of the Trust.

15.3 If the practitioner is a clinical academic, a further panel member may be appointed in accordance with any agreed protocol between the Trust and the relevant University.

15.4 The panel must also be advised by a senior HR professional.

15.5 The Case Manager should notify the practitioner of the panel members in writing

when notifying the practitioner of the hearing. Within 5 working days of their notification, the practitioner should raise with the Case Manager any objections to the panel members.

15.6 **Conduct of the hearing -** Part IV, Section 23 of MHPS outlines how Capability Hearings are to be conducted.

15.7 **The decision -** The panel has the discretion to make a range of decisions. A non-exhaustive list of possible decisions include:-

- No action required;
- Verbal agreement by the practitioner that there will be an improvement in clinical performance within a specified timescale confirmed in a written statement as to what is required and how it is to be achieved;
- First written warning to improve clinical performance within a specified timescale with a statement which is required and how this can be achieved;
- A final written warning that there must be improved clinical performance within a specified timescale and how this can be achieved;
- Demotion / Transfer
- Termination of employment.

15.8 The decision must be confirmed in writing to the practitioner within 10 working days of the hearing and communicated to the Case Manager within the same timescale. The letter to the practitioner must include reasons for the decision, confirmation of the right of appeal and notification of any intention to make a referral to the GMC or any other external professional body.

15.9 Any decision must be placed in the practitioner's personal file. A verbal agreement should remain live on the file for six months, first written warnings fortwelve months and final written warnings for twenty four months.

15.10 Appeals against a decision must be received in writing within 25 working days of the appeal hearing, submitted to the Director of Human Resources. Appeals must set out specific grounds upon which the practitioner wishes to base their appeal, otherwise the appeal may not be allowed.

15.11 **Capability Appeals Procedure -** Part IV, sections 28 to 46 of MHPS outline therole and structure of an appeal panel, the procedure and the communication of the decision.

15.12 **Termination of employment with performance issue unresolved -** If a practitioner leaves the Trust's employment prior to the conclusion of the above processes, the capability proceedings must be completed wherever possible. This applies whatever the personal circumstances of the practitioner.

15.13 Where during the capability process a practitioner becomes ill, appropriateaction should be taken under the Trust's Management of Ill Health Policy and Procedure and Part V and paragraphs 49-50 of MHPS.

15.14 Where a practitioner's employment is terminated on ill health grounds the Trust shall still take the capability procedure to a conclusion.

16.0 Part V of MHPS – Handling concerns about a Practitioner's Health

16.1 This part applies to the following circumstances:

- where the issues of capability or conduct are decided by the Case Manager to have arisen solely as a result of ill health on the part of the practitioner;
- where issues of ill health arise during the application of the procedures for addressing capability or conduct.

16.2 This section should be read in conjunction with the Trust's Management of Ill Health Policy and Procedure.

16.3 **In the event that the Case Manager considers that capability or conduct concerns may have arisen because of a practitioner's ill health**, he/she should refer the practitioner to Occupational Health. Once the Case Manager has the report from Occupational Health, he/she should decide whether he/she is satisfied that any concerns arise from ill health rather than misconduct or incapability.

16.4 Where there is impairment of performance solely due to ill health, disciplinary procedures would only be considered in the most exceptional of circumstances, for example if the practitioner concerned refused to co-operate with the employer to resolve the situation.

16.5 **Reporting Practitioners with health concerns to Regulatory Bodies -** If a practitioner's ill health makes them a danger to patients and he/she does not recognise this, or is not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and is potentially justifiable. Furthermore, NHS Resolution and the GMC must be informed irrespective of whether or not the practitioner has retired on ill health grounds.

17.0 Links with other Trust Policies and Procedures – Dispute Resolution, Freedom to Speak Up: Raising Concerns, Patient Complaints and SI Investigations

17.1 The overarching framework for managing any concern about a doctor should be through the MHPS procedures. MHPS is a contractual document for doctors employed in the NHS.

17.2 If a concern relates to allegations of bullying and harassment by a doctor, the Trust policy on Bullying and Harassment should be considered but the process and principles of MHPS should be followed. The similar applies to concerns raised through the Whistleblowing policy.

17.3 Patient complaints and SI Investigations are usually managed outside HR processes by the Patient Experience Team. If a complaint is upheld and/or there are recommendations/findings against a doctor through an SI investigation, the case should refer back to MHPS procedures and managed according to the MHPS principles.

18.0 Principles of Remediation

18.1 **Remediation** is the process of addressing performance concerns (knowledge, skills and behaviours) that have been recognised, through assessment, investigation,

review or appraisal, so that the practitioner has the opportunity to return to safe practice. It is an umbrella term for all activities which provide help;from the simplest advice, through formal mentoring, further training, reskilling and rehabilitation:

18.2 **Reskilling** is the process of addressing gaps in knowledge, skills and/or behaviours which result from an extended period of absence (usually over 6 months) so that the practitioner has the opportunity to return to safe practice. This may be, for example, following suspension, exclusion, maternity leave, career break or ill health

18.3 **Rehabilitation** is the process of supporting the practitioner, who is disadvantaged by chronic ill health or disability and enabling them to access, maintain or return to practice safely.

19.0 Remediation Procedures

19.1 LPT will offer early intervention when justifiable concerns emerge over the capability, conduct or health of a practitioner, with the aim wherever possible of remediation, reskilling or rehabilitation. The following principles of best practice build on the experience of the NHS Resolution (formally the National Clinical Assessment Service (NCAS).

20.0 Step 1 – Draft an action plan

20.1 Draft an outline plan setting out what can be done to address the identified needs. This outline can then inform discussions about decision making around engagement, reasonableness, proportionality, practicability and resourcing. The template for a Practitioner Action Plan (Appendix 9 may be used for this purpose).

20.2 The outline plan should address:

- Areas of concern
- Possible interventions
- Resources needed
- Potential support
- Timeframes
- Sources of evidence/information needed to demonstrate progress
- The role to which the practitioner will return if the programme demonstrates that the identified concerns have been addressed
- The implications for the practitioner if concerns are not addressed
- How the plan will be reviewed, how often and by whom.

20.3 The practitioner should be encouraged to share the outline plan with a professional representative at an early stage.

20.4 Where possible, interventions should be developmental, providing the practitioner with constructive feedback to encourage reflection and build insight into the ways in which practice and performance can change.

20.5 Some of the interventions that might be considered include:

- Supervised practice;
  Exposure to the full range of clinical scenarios with constructive feedback, structured reflection and supervised observation.

- Formative work based assessments;
  Case based reviews, mini-clinical evaluation exercises, objective structured clinical examinations (OSCE), on-site assessment and training (OSAT),video recording, simulation, multi-source feedback.
- Educational activities;
  Tutorials, workshops, courses, e-learning, focused reading.
- Specialist and health interventions;
  Behavioural coaching, occupational, psychological and specialist health (mental health and addiction) interventions, counselling (career or therapeutic), boundary awareness, cultural competence.
- Practitioner support;
  Mentoring, protected learning and development time, career guidance, Occupational Health, AMICA.
- Organisational support:
  Human Resources, legal advice, team or workplace mediation.

21.0 Step 2 – Agreeing to proceed (or not)

21.1 Identify the next steps for agreeing the plan or examine alternative actions if it isnot possible to reach agreement on the outline action plan. The employer should consider if it is reasonable to commit to the remediation plan. If the practitioner does not co-operate this may be seen as a lack of willingness onthe part of the practitioner to work with the employer on resolving performance difficulties.

21.2 The practitioner should be advised to talk the options through with an experienced and independent adviser i.e. Trade Union representative, Medical Defence Organisation etc.

21.3 Once agreed in principle and while a programme is still being finalised, the practitioner could be encouraged to participate in non-clinical learning activities for example, behavioural coaching, CPD, audit etc, which could be integrated into the action plan retrospectively.

21.4 If an 'in principle' agreement cannot be reached, other measures will need to be explored to ensure that patient safety and public protection are not compromised. Options may include:

- Restrictions to practice to areas which do not cause concern. The ongoing practicality of which should be considered.
- Retraining or re-specialising
- Working at a lower grade
- Specialist careers advice to help the practitioner onto a more appropriate career path
- Capability/disciplinary procedures
- Negotiated settlement
- Retirement (early, age)
- Referral to the regulator.

21.5 Should an individual disagree with the remediation programme the practitioner

should raise this in line with Stage 1 of the Trust Dispute Resolution procedure.

22.0 Step 3 – Develop the detailed plan

22.1 Once there is agreement on the outline action plan, populate the Practitioner Action Plan template to construct a detailed plan. An action plan is different to a Personal Development Plan (PDP). Development of a PDP is a 'routine' process related to appraisal and revalidation whereby an action plan is an 'extraordinary' process relating to achieving specific learning outcomes directedby a third party. The action plan should include objectives, interventions, use ofplacements, milestones, supporting information/evidence, funding estimates,cost sharing arrangements and actions to be taken if progress exceeds or falls short of expectations at specified review points.

22.2 NHS Resolution may be referred to during the process for support and may provide specific parts of the assessment if appropriate, such as an assessment of behavioural concerns, communicative competences etc.

22.3 In drawing up the detailed plan, the practitioner's welfare should also be considered. Objectives should be realistic and structured with timelines. Personal support, such as confidential mentoring, counselling or occupational health should be made available or accessible to the practitioner. Support may also be available from a defence organisation, professional association or a confidential voluntary support network.

22.4 A remediation/reskilling/rehabilitation programme may take place wholly or partly at the practitioner's usual workplace or might be arranged elsewhere. Remaining in the usual workplace will probably be the choice where working relationships remain good, where the team can absorb the additional workload and where an appropriate clinical supervisor can be found. Concerns raised through appraisal would normally be dealt with in this way, although a short period observing work in another organisation might be identified as a useful learning method.

22.5 Where further training at the practitioner's usual workplace is not appropriate an external placement may be necessary. External placements offer a number of benefits:

- Objective monitoring and reporting
- Experience of different ways of clinical and non-clinical working
- Temporary removal from a difficult working environment
- Fewer organisational commitments for the practitioner and more opportunity to focus on personal further training
- Practical demonstration of an organisations commitment to the remediationprocess.

22.6 The benefits of an external placement need to be balanced against resourcing external placements, the difficulty finding them and the difficulty they maycreate when the practitioner re-enters the original workplace. Use of a placement agreement is recommended in setting out an external placement.

23.0 Step 4 - Implement and monitor

23.1 The practitioner is responsible for completing the remediation programme. The

employer is responsible for following up the programme.

23.2 Once an action plan has started there should be close monitoring and collectionof evidence, as specified in the plan. The action plan template requires a reporting structure for collecting feedback from clinical supervisors, specialist trainers as well as from the practitioner who is expected to provide a portfolio of evidence supporting progress made. This will enable decisions to be made at the planned review points about whether objectives have been met and whether the programme should move on to the next milestone.

23.3 The monitoring process should involve regular meetings between the clinical Line Manager, the clinical/educational supervisor and the practitioner to measure progress formally against milestones. This will allow any lack of engagement with the process or lack of progress to be identified and dealt with quickly and effectively. This could include, if appropriate in the circumstance, rearranging activities, extending the deadlines, or potentially by early termination of the programme. If a programme is terminated early the Trust capability or disciplinary policy should be followed.

24.0 Step 5 - Complete the programme and follow up

24.1 If the concerns about the practitioner's performance have been resolved, the clinical Line Manager should agree arrangements for the practitioner to return to practice under the terms agreed. If the progress intended has not been made, alternative management actions will have to be considered, linking to Maintaining High Professional Standards guidance and the Trust capability or disciplinary policies.

24.2 The outcome should be confirmed in writing to all parties including the practitioner and any external stakeholders such as regulators or NHS Resolution.

25.0 Funding remediation

25.1 A remediation/reskilling/rehabilitation programme should not commence until there is a clear agreement on how the costs will be met. The main cost areas for consideration are:

- Reasonable adjustments to accommodate practitioner's health needs;
- Salary costs/remuneration for the practitioner undergoing further training;
- Locum cover costs to maintain normal patient services
- External placement costs (if necessary).
- Travel and subsistence costs during courses or placements;
- Other educational costs – behavioural coaching, communication skills etc;
- Fees from external bodies who may be needed to support further training.

25.2 In certain circumstances, namely where it can be shown that the responsibility of the individual doctor, flowing from professional and regulatory requirements, to keep themselves up to date and fit to practise has not been met, the costs of any remedial programme may fall on the individual doctor. In most cases however, the Trust would expect to meet the costs of remedial programmes, in line with its contractual and legal obligations.

26.0 Training needs

26.1 There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role specific.

27.0 Monitoring Compliance and Effectiveness

Page / Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
	Number of doctors with concerns in the last 12 months (Capability, Conduct, Health).	Via Medical Staffing Department	Medical Director	Annually
	Number of doctors who have undergone formal remediation in the last 12 months.	Via Medical Staffing Department	Medical Director	Annually
	Number of doctors who were suspended / excluded in the last 12 months.	Via Medical Staffing Department	Medical Director	Annually
	GMC Actions: number of doctors referred, Underwent GMC Fitness to Practice procedures, Had conditions placed on their practice, had their registration suspended in the last 12 months.	Via Medical Staffing Department	Medical Director	Annually
	NCAS Actions: Number of doctors about whom NCAS has been contacted;	Via Medical Staffing Department	Medical Director	Annually

28.0 Standards/Performance Indicators

TARGET/STANDARD	KEY PERFORMANCE INDICATOR
Care Quality Commission Fundamental Standards	Regulation 18 – Staffing Sufficient numbers of suitably qualified, skilled and experienced persons must be employed.

29.0 References and Bibliography

- National guidance and standards - NHS Resolution
- Good medical practice 2024 - GMC (gmc-uk.org)
- Doctor Support Service - GMC (gmc-uk.org)
- Being fair 2 - improving organisational culture in the NHS - NHS Resolution
- National Patient Safety Agency – How to conduct a local performance investigation https://resolution.nhs.uk/wp-content/uploads/2019/03/How-to-conduct-a-local- investigation.pdf

30.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.
- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.
- If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Training Requirements

Training Needs Analysis

Training topic:	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) X Role specific ☐ Personal development
Directorate to which the training is applicable:	All directorates in which doctors are working
Staff groups who require the training:	Responsible Officer, Medical Director, Associate Medical Directors, Clinical Directors, HR staff
Regularity of Update requirement:	2 yearly or as legislation changes
Who is responsible for delivery of this training?	Organised through Medical Staffing who will commission NHS Resolution or similar organisation to provide in house training specific to LPT needs.
Have resources been identified?	Yes, within Medical CPD funding
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	X ULearn ☐ Other (please specify)
How is this training going to be monitored?	Through the submission of annual reports by the Responsible Officer to NHS England

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	X
Support and value its staff	X
Work together with others to ensure a seamless service for patients	☐
Help keep people healthy and work to reduce health inequalities	X
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	Managing Concerns about Medical Staff
Date Screening commenced	19.12.2023
Directorate / Service carrying out the assessment	Medical Directorate
Name and role of person undertaking this Due Regard (Equality Analysis)	Catherine Holland, Head of Medical Staffing and Business
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The purpose of this policy is to outline, in the context of the nationally agreed framework "Maintaining High Professional Standards in the NHS", how a concern about medical staff may arise, how this might be managed and who might be involved.	
OBJECTIVES: This policy aims to provide a clear set of procedures which can bereferred to when concern arise about medical staff. The purpose is to support the delivery of a transparent and fair approach to the management of concerns of medical employees and to ensure that patient safety is the paramount consideration.	

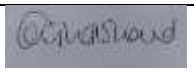
Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	*See below
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	*See below
Sexual Orientation	
Other equality groups?	

Data compiled by the GMC (GMC Data Explorer) has been considered in the development of the local Trust policy. Those findings noted that there is a consistently higher probability of referral to the General Medical Council Fitness to Practice Complaint department about doctors in the following groups:

- male doctors
- doctors aged 50 – 59
- doctors in the specialties of Surgery, Medicine and Psychiatry.

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	**No**
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4
If this proposal is low risk please give evidence or justification for how you reached this decision:
Whilst noting the research findings (described above), the recommendations in this local policy have been considered to determine if they will have different impacts on different groups of doctors in terms of their ability to gain access to help with remediation of aspects of their practice. The policy was sent to the local professional committee (Medical Local Negotiating Committee) and to all Medical Appraisers. Feedback was received from committee members and Appraisers. Where appropriate, the wording of the policy was

revised to reflect the comments. It is concluded that the implementation of the local policy will have no direct negative impact on access to remediation on the basis of gender, race, sexual orientation or religious belief.			
Signed by reviewer/assessor		Date	1.3.2024
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	1.3.2024

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Managing Concerns about Medical Staff**	
Completed by:	**Catherine Holland**	
Job title	**Head of Medical Staffing & Business**	**Date 19.12.2023**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	**All information to be collected is recorded in the document**
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	**Individuals will be required to provide information to support an investigation**
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	Potentially	**Information may be disclosed to the GMC if there is a Fitness to Practice concern**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**	**Information is used to support the process of investigation**
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	Potentially	**Performance investigation may lead to disciplinary action**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	Potentially	**Performance investigation may lead to disciplinary action**
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	
Date of approval	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 5 Issues affecting a doctor's

It is recognised that a doctor's performance can be affected by a complex range of issues. All of the issues listed below can affect performance, but not all will be amenable to remediation (this list is not exhaustive):

Skills and knowledge deficit - for example:

- A lack of training and education
- Lack of engagement with continuing professional development and/ormaintenance of performance
- A doctor trying to take on clinical work that is beyond their current levelof skill and experience.

Behaviours and attitudes – for example:

- Loss of motivation, interest or commitment to medicine or theorganisation through being stressed, bored, bullied
- Being over-motivated, unable to say no, overly anxious to please
- Poor communication skills
- Poor timekeeping
- Poor leadership/team working skills.

Context of work – for example:

- Team dysfunction
- Poor managerial relationships
- Poor working conditions
- Poor or absent systems and processes.

Environment – for example:

- Marriage/partnership break up
- Financial concerns.

Health concerns including capacity and/or capability – for example:

- Physical conditions including drug and alcohol misuse
- Psychological conditions including stress and depression
- Cognitive impairment/deterioration.

Probity – for example:

- Boundary issues
- Altering clinical records
- Conflicts of interest

Criminal behaviour – for example:

- Falsifying expenses
- Theft
- Assault.

Gauging the level of concern

This section provides a generic framework which can be used to gauge the level of a concern and improve consistency in response and management of concerns. It also covers the use of information for monitoring at both an individual and organisational level.

Definitions of level of concern:

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

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

- **High level (Red) concern** = Patients, staff or the doctor have been harmed. This will be a medium level situation plus a serious untoward incident or complaint requiring a formal investigation. This includes criminal acts and referrals to the GMC.

An example of a categorisation framework is given overleaf to illustrate the potential merit of such an approach.

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

What reputational risks exist?		
Organisational or professional reputation is not at stake but the concern needs to be addressed by discussion with the practitioner.	Organisational or professional reputation may also be at stake	Organisational or professional reputation is at stake
Does the concern impact on more than one area of Good Medical Practice?		
Concern will be confined to a single domain of Good Medical Practice May include one or more of following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	Concern affects more than one domain of Good Medical Practice May include one of following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action	May include a serious untoward incident or complaint requiring a formal investigation. This includes criminal acts and referrals to the GMC
Which factors reduce levels of concern?		
De-escalation from moderate to low: Reduction to low or minimal impact Reduction in the likelihood of recurrence Evidence of completion of effective remediation	De-escalation from high to moderate: Reduction in impact to moderate Reduction in the likelihood of recurrence Evidence of insight and change in practice	
Which factors increase levels of concern?		
	Escalation from low to moderate: Increase in impact to Moderate Likelihood of recurrence is certain No evidence of insight or change in practice ease	Escalation from moderate to high: Increase in impact to severe Increase in likelihood of recurrence No evidence of remorse, insight or change in practice

How much intervention is likely to be required?		
Insight, remorse and change in practice will be evident Remediation is likely to be achieved with peer support The individual doctor has no other involvement in incidents or has outstanding or unaddressed complaints/concerns The remediation plan should take no longer than four weeks to address	Insight, remorse and change in practice may be evident Remediation is likely only to be achieved through specialist support The remediation plan should take no longer than three months to address	Remediation will only to be achieved through specialist support The remediation plan will take upwards of three months to address and may include planned periods of supervised practice.

Appendix 7 Supporting resources for doctors undergoing investigation

It is acknowledged that doctors who are the subject of an investigation may find the experience frightening, frustrating and potentially very isolating. It is recognised that there is potential for health or behavioural issues to develop as a result of an investigative process.

There are a range of organisations, both locally and nationally, which can offer help, assistance and practical support for the doctor and their immediate family. Some of those organisations are listed below (this is not an exhaustive list):

Local Organisations

Organisation	Telephone	Website	Summary
Occupational Health Service,Glenfield Hospital, Baldwin Lodge	0116 225 5431		The Occupational Health Service provides specialist advice on all aspects of the relationship between work and health. It is independent, impartial and available to anyone in the Leicestershire Partnership NHS Trust – staff, staff representatives as well as management.
AMICA Confidential Telephone CounsellingService	0116 254 4388	www.amica-counselling.uk	AMICA Staff Counselling and Psychological support service is an NHS based staff counselling service which provides confidential telephone and face to face counselling services. Staff may discuss any difficulties they are faced with regardless of whether they are work related or personal.
LAMP Directory	0116 255 6286	www.lampdirect.org.uk	A community mental health website for the people of Leicester, Leicestershire, and Rutland. Whether experiencing mental health difficulties, caring for someone in mental distress, working within the mental health community or just has an interest in mental health issues.

National Organisations

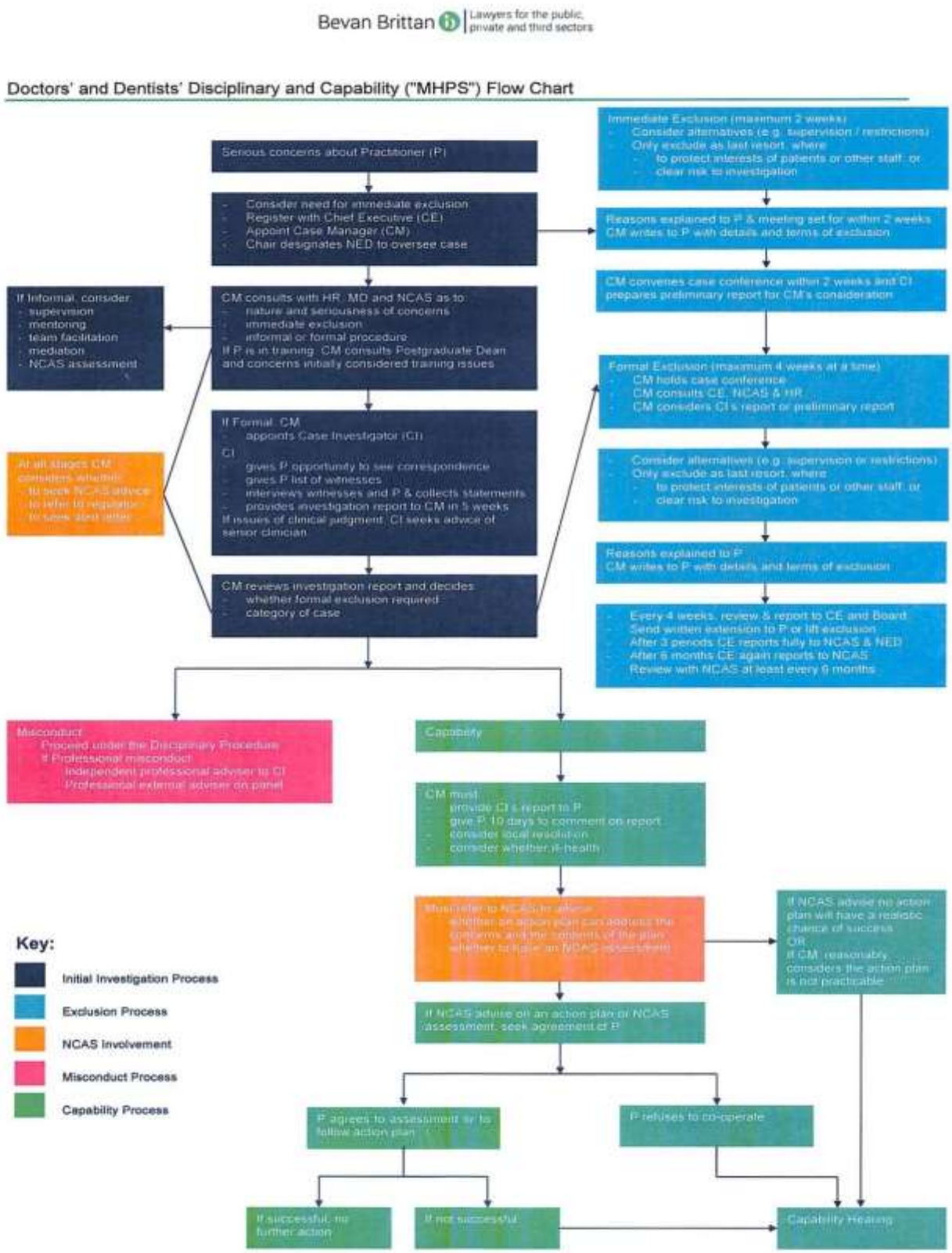
Organisation	Telephone	Website	Summary
BMA	0300 123 1233	www.bma.org.uk	The British Medical Association is the trade union and professional body for doctors in the UK.
BMA CounsellingService	0330 123 1245	https://www.bma.org.uk/advice-and-support/your-wellbeing/wellbeing-support-services/counselling-and-peer-support-for-doctors-and-medical-students	24-hour support with access to trained counsellors.
Royal College of Psychiatrists (SupportService)	0207 235 0412	www.rcpsych.ac.uk Email: pss@rcpsych.ac.uk	A confidential support and advice telephone service for members of the College.
Doctors' Support Network		www.dsn.org.uk Email: info@dsn.org.uk	The Doctor's Support Network (DSN) is a confidential self-help group for doctors with mental health concerns.
Support 4Doctors		www.support4doctors.org	An online portal of information for UK doctors and a project of the Royal Medical Benevolent Fund. Provides access to a wide range of specialist advice and support for doctors and their families.
Royal Medical Benevolent Fund	0208 540 9194	www.rmbf.org	A leading charity for the medical profession set up to help those looking to return to work after accident, illness or other crisis; those looking for help to avert a crisis; and those needing help to retain dignity and self-sufficiency, where employment is no longer feasible.

British Association of Physicians of Indian Origin (BAPIO)	01234 212 879	www.bapio.co.uk	These organisations provide support for international doctors for cultural, linguistic or equality issues.
British International Doctors Association	0161 456 7828	www.bidaonline.co.uk	
Sick DoctorsTrust	0370 444 5163	www.sick-doctors-trust.co.uk	Provides early intervention and treatment for doctors suffering from addiction to alcohol or other drugs

Medical Defence Unions

Organisation	Telephone	Website	Summary
Medical DefenceUnion	0800 716 646	www.themdu.com Email: advisory@themdu.com	The MDU is led and staffed by doctors who have real-life experience of the pressures and challenges doctors face every day. They have expertise in medio-legal issues, complaints and claims.
Medical Protection Society	0800 561 9090	www.medicalprotection.org/uk Email: info@medicalprotection.org	The MPS offers support to members with the legal and ethical problems that arise from their professional practice. Members commonly seek help with clinical negligence claims, complaints, medical council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Appendix 8 Doctors and Dentists Disciplinary and Capability (MHPS) Flow Chart



PART 1 – AGREEMENT

Name of practitioner	
Grade and specialty	
GMC number	
Address	
NHS Resolution case number (where applicable)	

1. Purpose

The purpose of this plan is for the practitioner named above to address the performanceconcerns identified by *[NHS Resolution/local procedures/college or other educational body/health regulator – add or delete as necessary]*

2. Roles and responsibilities for management of this plan

The Clinical Director identified overseeing the action plan is:

Name	
Job title	

The Clinical Lead is:

Name	
Job title	

The Clinical Supervisor is:

Name	
Job title	

3. Progress review

The plan is expected to last [*add duration*] months. Progress will be formally reviewed by theClinical Director and by the Clinical Lead every [*add interval*] months and at the end of the plan.

The named practitioner should be able to demonstrate satisfactory and incremental progressthroughout the programme and continuing ability to reflect and learn from [his/her] own and [his/her] colleagues' practice.

4. Post to which the practitioner is likely to return

On successful completion of the plan it is proposed that named practitioner will continue inpractice or return to practice in the clinical post/area described below.

Name of post	
Broad description of post/clinical area	
Employer/Contracting body	

The [*Clinical Director – insert name*] will consider taking management action in the followingcircumstances, if the expected progress towards objectives is not demonstrated:

1. Where failure to progress occurs at the first or second milestone, continuing with the action plan but re-assessing objectives can be considered. A change of objective willonly be agreed to where there is clear evidence of progress even though falling shortof the performance standard defined in the plan. The overall time allotted to the action plan will not be extended.

2. A failure to progress in achieving the agreed objectives may result in [*sanctions – add relevant possibilities such as use of disciplinary action, use of disciplinary/capability procedures, referral to regulatory body*] and/or a new final employment goal such as redeployment. These possibilities will be considered if, in the opinion of the clinical supervisor and Clinical Director, the objectives are not likelyto be met in the remaining time allocated to the action plan despite the practitioner having ample opportunity to demonstrate progress.

3. If a failure to progress raises concerns in relation to patient safety or professionalprobity, the Clinical Director may make a referral to the General Medical Council.

4. If a failure to progress is related to sickness absence, it may be appropriate to deferthe plan's completion date. The normal quota of annual leave may be taken during the period of the action plan, but this must be pro-rata. Any period of sickness absence greater than that covered by self-certification must be supported by a doctor's certificate. A cumulative absence due to illness of more than [*Add – for example, two weeks in six months*] will trigger a referral to the Occupational Health Service unless seen as unnecessary in the opinion of the Clinical Director and Clinical Supervisor. Reasons for not making an OH referral will be given.

   Where an organisational action plan has been agreed (in addition to this plan for the individual practitioner) progress will be reported to the practitioner at review points. [*Deleteas necessary*]

5. Agreement

This plan has been developed with the cooperation of all parties who are satisfied that the identified objectives reflect the issues identified in:

- the decision of the regulator when this body is involved and/or
- the assessment report and recommendations for NHS Resolution cases and/or
- the review report and recommendations from the Royal College and/or
- local investigation
- [Add or delete as necessary]

All parties agree to the objectives set out in the plan and will take forward the programmeas set out in the plan, adhering to the accompanying notes. If further objectives need to beadded to the plan during the course of the programme, these may be added following agreement of all parties.

	Name and organisation	*Signature*	*Date*
Practitioner			
Responsible Officer			
Clinical Director			
Clinical Lead			
Additional participants as necessary			

PART 2 – OBJECTIVES

Objective 1

Area to be addressed:	
Specific objective(s)	
How	
Where	
Supervisor(s)	
Resources required [Including funding and provider of funding]	
Timescale	
Milestones	
Supportive evidence	

Objective 2

Area to be addressed:	
Specific objective(s)	
How	
Where	
Supervisor(s)	
Resources required [Including funding and provider of funding]	
Timescale	
Milestones	
Supportive evidence	

Copy this block for each area of concern and related objective(s) and set out how the objectives will be met.

PART 3 - REVIEW

Objective 1		
Review date		
Clinical Supervisor comments		
	Signed:	*Date:*
	Proposed Summary Score:	
Practitioner comments		
	Signed:	*Date:*
Clinical Director comments		
	Signed:	*Date:*
	Agreed Summary Score:	

Objective 2 etc.		
Review date		
Clinical Supervisor comments		
	Signed:	*Date:*
	Proposed Summary Score:	
Practitioner comments		
	Signed:	*Date:*
Clinical Director comments		
	Signed:	*Date:*
	Agreed Summary Score:	

Note – as in part 2, copy this block for each area of the plan. NHS Resolution suggests use of summary scores to record progress:
0 = no progress, 1 = partial progress, 2 = objective fully achieved.

PART 4 – SIGN OFF

The signatures below **confirm** the completion of the plan by the practitioner, who agrees to make this document available to the future appraiser/appraising body. In this way, progress can be maintained and the appraisal process is informed by the plan.

	Name	*Signature*	*Date*
Clinical Supervisor			
	Final comments		
Practitioner			
	Final comments		
Clinical Director			
	Final comments		

Other parties should sign here, as necessary:

	Signature	*Date*
Name		
Organisation		
Name		
Organisation		