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PRIMARY MEDICAL SERVICES PERFORMERS LIST

***ADVICE FOR HEALTH AND SOCIAL SERVICES
BOARDS ON LIST MANAGEMENT***

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This guidance should be read in conjunction with the Health and Personal Social Services (Primary Medical Services Performers Lists) (Amendment) Regulations (Northern Ireland) 2008 (SR 2008 No. 434)

1. BACKGROUND

- 1.1 The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004, which came into operation on 1 April 2004, introduced primary medical services performers lists (lists) and required Boards to maintain and publish such a list for their respective areas. From the introduction of these regulations, a doctor has to be listed as a primary medical performer in order to treat Health Service patients in a primary care setting. These arrangements gave Health and Social Services Boards (Boards) responsibility for admission of a doctor to a list and removal from the list subject to strictly defined criteria set out in the regulations.
- 1.2 Certain grounds for refusing a doctor admission to, or removal from, a list are mandatory. Regulation 7(1) of the above regulations sets out the conditions for mandatory refusal and regulation 9 (1) for mandatory removal.
- 1.3 In contrast to England and Wales, but similar to Scotland, in 2004 we retained the Tribunal, constituted in accordance with Schedule 11 to the Health and Social Services (Northern Ireland) Order 1972. The Tribunal undertakes independent investigations of any case referred to it by a Board to consider cases of discretionary refusal, removal or suspension from a list on the grounds of suitability, efficiency or fraud.
- 1.4 The structure here therefore did not provide a framework within which Boards could take action swiftly if a doctor's personal and/or professional conduct, competence or performance gave cause for concern. Boards were required to refer these cases to the Tribunal or the General Medical Council (GMC), the body which registers and regulates UK doctors.
- 1.5 In order to introduce control and management measures that will allow Boards to take steps that may prevent a doctor's performance reaching a point that requires censure by the Tribunal or GMC, the performers list regulations have been amended to provide Boards with the powers to suspend or impose conditions on a doctor. This will allow Boards to assure themselves that applicants to a performers list are suitable and that they continue to meet standards of conduct and performance needed to provide safe service to their patients.
- 1.6 These new provisions, along with the requirement for an enhanced criminal record check and changes to Board list arrangements, will maintain parity, as far as possible with the rest of the UK.

2. AMENDING LEGISLATION

- 2.1 Following the introduction of the necessary primary legislation, the Health (Miscellaneous Provisions) Act (Northern Ireland) 2008, the 2004 performers list regulations have been amended. The amending regulations, The Health and Personal Social Services (Primary Medical Services Performers Lists) (Amending) Regulations (Northern Ireland) 2008, came into operation on 8 December 2008.

3. GENERAL

- 3.1 **This guidance provides advice for Boards on managing the new provisions introduced by the amending regulations. It is not a substitute for the provisions in the Performers Lists Regulations and should not be seen as such. It supplements guidance (circular HSS(PCD) 7/2004), issued by the Department in June 2004 to coincide with the introduction of the Performers List Regulations. Any decisions taken by Boards must comply with the provisions in the Regulations and should also refer to the appropriate regulation when appropriate.**
- 3.2 The guidance describes procedures that apply in Northern Ireland only. Any references to notification of decisions in writing include electronic notification.
- 3.3 References to Boards in this document mean the four Boards (under current structures) or their successor organisation, the Regional Health and Social Care Board, from April 2009.
- 3.4 Although the Boards delegate responsibility to the Central Services Agency (CSA) for managing list management processes, the CSA has management accountability to the Boards for its work. Legal responsibility and accountability for decisions to include, conditionally include, contingently remove, remove and suspend a doctor rest with the Boards. Such decisions should always be taken by the Boards.

4. EQUALITY AND FAIRNESS

- 4.1 There is no place for discrimination on grounds of gender, faith, race, disability, age or sexual orientation in the operation of any of the procedures dealt with in this guidance. No person should be treated less favourably than anyone else would be treated in the same or similar circumstances. Every case should be dealt with according to individual circumstances.

- 4.2 Any decisions taken by Boards need to be procedurally robust. They will want to ensure that their decisions are likely to be held to be lawful if they come under judicial scrutiny. Boards that act inappropriately may well find their decisions overturned if a doctor appeals to the Department and may be vulnerable to other legal challenge.

5. INVOLVING OTHER BODIES

- 5.1 Local arrangements need to command the confidence of doctors locally. Boards are likely to find that involving Local Medical Committees (LMCs) will help to publicise the local procedures within the profession, and to develop them, in a way that maintains their confidence. Although the law does not compel Boards to consult LMCs on these matters, it would be good practice to do so.
- 5.2 LMCs have always been able to contribute to local management of primary medical services through local arrangements. They are likely to have views on how the local panels dealing with efficiency and fraud issues might be constituted and operated. They may be able to identify sources of professional advice that will have the confidence of clinicians. Where ill-health may be the cause of poor performance, the LMC's networks may be able to offer support to the doctor, and to take responsibility for alerting the Boards if the doctor is refusing help and putting patients at risk.
- 5.3 The National Clinical Assessment Service, which is part of the National Patient Safety Agency (NPSA), provides a service to support Boards in dealing with doctors whose performance gives cause for concern. It provides advice about the local handling of cases and, where necessary, carries out clinical performance assessments to clarify areas of concern and make recommendations on how difficulties may be resolved.
- 5.4 Boards are advised to contact and consult NPSA as early as possible when action is being considered in any case involving clinical performance or competence. They should also keep in regular touch with NPSA whilst a case is progressing. The early intervention and continuing involvement of NPSA is intended to help Boards maintain momentum when dealing with performance or competence concerns. See the Investigations section (paragraph 24) for more about involving NPSA.
- 5.5 Boards are now required to notify NPSA of decisions they take to refuse to admit or conditionally admit doctors to their lists, or to suspend, remove or contingently remove doctors from their lists. In individual performance or competence cases, except where immediate suspension is necessary to protect patients, any Board that has not already involved NPSA in

attempting to resolve the case is advised to contact it before suspending a doctor or applying any of the sanctions available under the Performers Lists Regulations.

6. LOCAL REGULATION

- 6.1 The provisions now included in the Performers Lists Regulations will allow Boards to regulate the performance of primary medical services in their areas more effectively. Formally, this means that Boards have the power to prevent a doctor from performing services, or to place restrictions (conditions) on a doctor with which the doctor must comply.
- 6.2 Since a doctor must be on a Board's Performers List to perform services for patients, a Board will do this by:
- refusing to admit the doctor to its list (Mandatory refusal -Regulation 7);
 - placing the doctor on its list subject to conditions (Conditional inclusion - Regulation 8A);
 - removing the doctor's name from its list (Mandatory removal - Regulation 9) (where the doctor has not performed GMS for the preceding 12 months - Regulation 10);or
 - contingently removing the doctor's name from its list (that is, permitting the doctor's name to stay on its list only if the doctor agrees to follow, and then observes, the Board's conditions) (Contingent Removal - Regulation 10A).
- 6.3 A Board can also suspend the doctor's name from its list and so prevent the doctor from performing general medical services, if this is needed to protect patients or is otherwise in the public interest, whilst it:
- considers whether to remove the doctor from its list under regulation 9 or contingently remove under regulation 10A;
 - considers whether or not to refer the case to the Tribunal or regulatory body, the General Medical Council;
 - awaits a finding of the Tribunal; or
 - waits for a decision affecting the doctor of a court anywhere in the world or of a licensing or regulatory body.

7. ENHANCED CRIMINAL RECORD CERTIFICATES – ACCESS NI

- 7.1 From 8 December 2008 the Performers List Regulations include the requirement that any doctor applying to join a Performers List must provide an enhanced criminal record certificate under section 113B of the Police Act 1997. A doctor already on a list will have to provide a certificate on request.
- 7.2 Under the Safeguarding Vulnerable Groups (NI) Order 2007, from October 2009, doctors will be required to register with the new Independent Safeguarding Authority and will be subject to continuous monitoring. Enhanced disclosures will be part of the registration process and existing doctors will be phased into the scheme over 5 years.

8. LIST MANAGEMENT AND GMS CONTRACT DISPUTES

- 8.1 The steps Boards may take under the Performers Lists Regulations to regulate the performance of primary medical services are quite distinct from the arrangements they have for ensuring that GMS contractors comply with their contracts to provide services. The two systems should not be confused. However, when parallel investigations under the Performers List Regulations and the GMS Contract Regulations are necessary, care should be taken to keep the issues separate and to make the reasons for the investigations clear to the subjects of the investigations.

9. STATISTICAL INFORMATION

- 9.1 Statistical information about the decisions Boards have taken under the Performers Lists Regulations will be collected annually by the Department. Boards should keep records of the decisions they take in the following categories:
- mandatory decisions to refuse to include a doctor onto their list;
 - mandatory decisions to remove a doctor from their list;
 - conditional inclusion decisions;
 - contingent removal decisions; and
 - suspensions.

- 9.2 Maintaining these records is quite distinct from the obligation Boards have to notify persons specified in regulation 14 of the Performers List Regulations, whenever they take decisions under the regulations about individual doctors.

NEW PROVISIONS FROM 8 DECEMBER 2008

10. CONDITIONAL INCLUSION – REGULATION 8A

- 10.1 Boards may consider that a doctor can be included in their performers lists subject to certain conditions. The aim of the conditions must be:

- to prevent any possible prejudice by the doctor's inclusion to the efficiency of primary medical services (the "efficiency" test); or
- to prevent any attempt by a doctor to secure personally or for another person any financial or other benefit to which they are not entitled (the "fraud" test).

- 10.2 It should be noted that the "suitability" test under which a Board can refer a case to the Tribunal for disqualification cannot be considered in respect of "conditional inclusion". The effect of the law is that a doctor is either suitable or unsuitable. There are no degrees of suitability.

- 10.3 Conditional inclusion will also not be appropriate where an application has been deficient. A Board may not, for example, admit a doctor to its performers list on the condition that evidence in support of the application is received within "x" months.

- 10.4 The "efficiency" grounds may be used when the inclusion of the doctor on the Board's list could be "prejudicial to the efficiency of the service" that is performed. Broadly speaking, these are issues of competence and quality of performance. They may relate to everyday work, inadequate capability, poor clinical performance, bad practice, repeated wasteful use of resources that local mechanisms have been unable to address, or actions or activities that have added significantly to the burdens of others in the health service (including other doctors).

- 10.5 Examples of issues which would fall under inadequate capability, poor clinical performance or bad practice include:-

- out of date clinical practice;
- inappropriate clinical practice arising from a lack of knowledge or skills that would put patients at risk;
- incompetent clinical practice;

- inability to communicate effectively;
- inappropriate delegation of clinical responsibility;
- inadequate supervision or delegation of tasks; or
- ineffective team working skills.

- 10.6 “Fraud” is not defined in law but there is a common understanding as to its definition. It happens when someone has obtained or attempted to obtain resources to which they are not entitled. Fraud may involve the misappropriation (or attempted misappropriation) of health service resources for personal gain or the gain of others.
- 10.7 Providing that there are sufficient substantiated facts to satisfy a Board that a doctor has secured (or attempted to secure) financial or other benefits personally or for others, and that doctor knew there was no such entitlement, a criminal conviction is not necessary in order for a Board to impose conditions on that doctor’s inclusion or continued inclusion on the list.
- 10.8 Where the doctor is the subject of an ongoing investigation by the Police, Counter Fraud Unit or regulatory body, this does not prevent an investigation by a Board into unrelated matters taking place but it would be advisable to consult the relevant organisation before commencing such investigations. Where a Board investigation is already under way and the Board becomes aware of another investigation, the Board should continue and complete its process and again liaison with the relevant body should take place. The Department would always expect a doctor to declare the outcome of any professional, civil or criminal sanctions to the Board.
- 10.9 If a doctor fails to comply with any condition or conditions imposed by the Board, the Board may remove the doctor from its list.
- 10.10 Information that should be considered by a Board when considering conditional inclusion is included at Annex A.

11. CONTINGENT REMOVAL FROM A LIST – REGULATION 12A

- 11.1 Contingent removal enables a Board to take action to protect patients without removing a doctor from its list. Conditions are imposed on the doctor’s continued inclusion on the list to:
- prevent any prejudice to the efficiency of the services (in an “efficiency” case); or
 - to prevent any attempt by a doctor to secure personally or for another person any financial or other benefit to which they are not entitled (in a “fraud” case).

- 11.2 Contingent removal cannot be imposed in a “suitability” case. The effect of the law is that a doctor is either suitable or unsuitable. There are no degrees of suitability.
- 11.3 In efficiency cases the conditions imposed might address poor performance or clinical shortcomings by requiring additional training or supervision in a particular area of practice. Where there has been previous fraud or dishonesty, the conditions might limit the doctor’s direct access to public funds or require the making of additional checks on claims. These examples are not of course exhaustive.
- 11.4 If the Board concludes that the doctor has failed to comply with any condition or conditions it has imposed, it can decide to vary the conditions, impose new conditions, or remove the doctor from its list.
- 11.5 Information that should be considered by a Board when considering contingent removal is included at Annex A.

12. REVIEW OF DECISION TO IMPOSE CONDITIONS

- 12.1 Boards are entitled to review the conditions they impose when they consider it would be appropriate. Indeed they may, if they wish, set out a date on which they intend to review the conditions as part of an original decision. That might be appropriate if, for example, the original conditions relate to mentoring or working under supervision. On review a Board may retain, vary or remove the conditions.
- 12.3 Boards are obliged to review conditions if the doctor asks in writing for a review as long as the request is made:
- no earlier than three months after the date on which the Board imposed the conditions; or
 - no earlier than six months after the date of any previous review.

The above time limits should not prevent a doctor with new evidence from seeking a review at any time.

13. SUSPENSION

13.1 Concern about a doctor's conduct or performance may come to light in a number of ways, for example as a result of:

- concerns expressed by other health professionals, health care managers and/or non-clinical staff;
- annual appraisal;
- clinical governance procedures and/or clinical audit;
- complaints about care from patients or from relatives of patients;
- information from licensing and regulatory bodies; or
- information from the police.

13.2 Lasting damage can be caused to a doctor's reputation and future career by unfounded and malicious allegations. Any and all allegations, including those made by patients or relatives of patients, or concerns expressed by colleagues, must be investigated properly to establish the facts.

13.3 Suspension is not a disciplinary sanction. It is intended to protect the interests of patients, staff and the doctor who is suspended. It should therefore be a rare event. Misuse of the suspension power can result in injustice, in damage to the doctor's reputation, career and personal life, and in waste of Health Service resources. Therefore it should only be imposed once the Board has considered whether there is a case to be answered and whether it has reasonable and proper cause to suspend. This is likely to be where there is:

- compelling evidence of culpability, of seriously sub-standard performance or lack of competence;
- sufficient evidence to warrant suspension pending detailed further investigation; or
- an allegation or allegations that are sufficiently serious to justify suspension whilst an investigation is undertaken.

13.4 A doctor who is suspended from a list is still treated as being included in that list in relation to any application the doctor may make for inclusion in another list. While suspended, the doctor cannot perform any aspect of primary medical service for any patient.

13.5 For this reason, alternatives to suspension in the interests of the doctor and of patients should be considered carefully before any decision is taken to suspend. For example the Board could consider contingent removal or ask the doctor to withdraw voluntarily from performing certain duties, and/or find suitable alternative work for the doctor away from direct patient contact, whilst investigations continue.

14. Criteria for Suspension

14.1 The Regulations permit Boards to suspend doctors if this is necessary to protect patients or if it is otherwise in the public interest. It is important that a Board which has suspended a doctor is able to substantiate its decision against these criteria.

14.2 Although the following examples are not exclusive, suspension to protect patients may be thought necessary if there is evidence of sub-standard clinical practice or personal behaviour, or if there are investigations or proceedings involving serious offences such as those involving sex or violence. A public interest justification for suspension might be said to exist if:

- allowing the doctor continued access to staff, patients or records might prejudice a major fraud investigation significantly, whether the investigation is being undertaken by Counter Fraud Unit or the police; or
- allowing the doctor to continue to perform the services would be likely to cause serious disruption to the efficient delivery of local health care or services to patients.

15. Period of Suspension

15.1 Suspension should last no longer than is necessary and in most cases can last no longer than six months (paragraph 15.3 refers).

15.2 This means that it is essential for Boards to commit the resources necessary to deal with the cause of the suspension and to take substantive action to refer the case to the Tribunal or regulatory body, contingently remove the doctor from the Performers List, or permit the doctor to return to work without conditions, as quickly as possible.

15.3 A Board may suspend a doctor:

- whilst it decides whether or not to remove or contingently remove the doctor from its list or while it considers whether to refer the case to the Tribunal or General Medical Council. A Board must specify the period of the suspension and that period may not exceed six months;
- whilst awaiting the outcome of a regulatory body or court investigations/proceedings. In these circumstances a suspension may remain in force until the outcome is decided. Once an outcome has been reached, a Board may impose a further period of suspension, but the further period can be no longer than six months, and the suspended doctor must be told the length of the additional suspension;
- when it has decided to remove or contingently remove the doctor from its Performers Lists, but before such a decision takes effect legally. This means during the period in which the doctor can decide to make an appeal against the removal or contingent removal, or, if an appeal is made, until the Department has dealt with the appeal. Such a suspension will be effective between the date on which a doctor is given notice of suspension and the expiry of the appeal period or the date of the Department's determination of the appeal.

15.4 If the GMC's Interim Orders Committee has decided to suspend a doctor's name from the Medical List, a Board might want to consider taking an equivalent decision to suspend the doctor from the performers list. This will help to reinforce safeguards intended to prevent any attempt that might otherwise be made by a suspended doctor to obtain work as a primary medical performer elsewhere in the health service. It will also ensure that payments can still be made to the suspended doctor.

16. General Procedures for Suspending a Doctor

16.1 A Board may suspend a doctor with immediate effect. When suspension is seen to be necessary, Boards are obliged to:

- give the doctor notice of the allegation, details of the action it proposes to take, and why. This notice can be given in writing or verbally. If it is given verbally it should be followed up immediately in writing, using electronic transmission or a courier if necessary;

- give the doctor an opportunity to put a case to the Board at a hearing. This notice may be included in the written notice of the action the Board proposes to take.
- 16.2 If the doctor attends the hearing, the Board shall take into account any representations made at the hearing in relation to its decision to suspend. The Board shall notify the doctor the outcome and the notice should include the facts it has relied on, its reasons, and information about the doctor's right to seek a review of the decision.
- 16.3 If the doctor does not want a hearing or fails to attend a hearing, the Board should advise the doctor about the right to seek a review of the decision to suspend.
- 16.4 Boards should follow the same procedure if they find it necessary to, and have the powers to, extend periods of suspension. They should give the doctor at least seven days notice of any such decision.
- 16.5 The above procedure is intended to allow Boards to act quickly and effectively to protect patients and the public interest. If temporary measures can be put in place to protect patients and address public interest concerns, Boards should consider whether to hold a hearing before deciding to suspend a doctor.
- 16.6 Other Boards will want to be aware of decisions taken to suspend a doctor from the Performers List. The Department considers that it would be good practice if:
- suspension decisions are reported to other Boards by the "host Board" (see paragraph 19(1) regarding "host Board");
 - at each of its meetings the Regional Performers List Committee receives an update on each suspension from the host Board.

17 Reviewing and Removing Suspensions

- 17.1 The Regulations permit a Board to review a decision it has taken at any time, and in certain circumstances, they also permit the affected doctor to seek a review. Where a Board has imposed a suspension as a matter of urgency, for example, the Board might choose to limit the period of suspension if the doctor agrees to a review hearing on an agreed date, before the end of that period. A decision can be taken at the hearing on whether to extend or to remove the suspension.

17.2 If the Board decides to review its decision, it must give the suspended doctor notice, and the opportunity to make written representations and request a hearing if so desired.

17.3 When a suspended doctor asks for a review, the Board must review the suspension if the request for review is made after:

- three months from the initial decision to suspend; or
- six months from the decision on any previous review.

The above time limits should not prevent a doctor with new evidence from seeking a review at any time.

17.4 On review, a Board can:

- maintain the suspension;
- revise the period of suspension; or
- remove the suspension.

17.5 Where the suspension is a result of Tribunal, regulatory body or criminal investigations or proceedings, and the outcome is exoneration of the doctor, the Board must remove the suspension. If the outcome is a finding against the doctor, the Board will need to consider whether it has grounds for removing or contingently removing the doctor from its Performers List. This may necessitate a further suspension up to a maximum of six months.

18. Payments to Suspended Doctors

18.1 The entitlement of suspended doctors to continued payments from their partnerships depends on the nature of the partnership agreement. The contractor may be able to receive the costs of a locum to cover the absence of a doctor who is suspended, up to a set maximum, subject to certain conditions and if the Board considers this is necessary. In GMS such payments are governed by paragraph 11 of the Statement of Financial Entitlements (NI).

18.2 To the extent that a doctor's income is not maintained to a certain level whilst suspended, a separate determination will be made on behalf of the Department requiring Boards to make payments to a suspended doctor. Responsibility for taking into account any Income Tax or National Insurance liability will rest with the Board. Boards are therefore advised to

contact the Inland Revenue if they have any doubts about Income Tax and National Insurance liabilities.

NEW LISTING ARRANGEMENTS

19 DOCTORS WHO WORK IN MORE THAN ONE BOARD AREA

- 19.1 The regulations make provision for a doctor who is on one Board's Performers List to perform primary medical services in any Board area. Doctors should apply to the Board in whose area they do most work. This Board will be known as the "host" Board.
- 19.2 There are benefits to doctors in being on the Performers List of the Board in whose area they do most work. This allows them to take better advantage of the support the Board offers in terms of continuing professional development, appraisal arrangements and through involvement in local service development activity.
- 19.3 It would be good practice if Boards were to continue to review their Performers Lists periodically in order to maintain contact, to confirm that the entries are up to date, and to ensure that individual members continue to perform services in the area. Boards have the ability to remove from their list any doctor who has not performed services in the Board area in the preceding 12 months.
- 19.4 The provision in paragraph 19.1 is a temporary arrangement until the Regional Health and Social Care Board comes into operation from April 2009. It should ensure that if suspended, a doctor will not be able to work in another Board's area.

20. DOCTORS' RIGHT TO WITHDRAW FROM A LIST

- 20.1 Except in the circumstances described in paragraph 21, a doctor can withdraw from a Board's list at any time. Having given notice of an intention to withdraw, the doctor can also rescind the notice at any time before the Board formally removes the doctor's name from its list. The date of removal should be three months from the date of the notice from the doctor, or an earlier date if the Board agrees.
- 20.2 A doctor must withdraw from a Board's list if admitted to the Performers List of another Board. If this happens, the Board should remove the doctor's name from its list immediately. This is treated as a voluntary withdrawal from the Board's list on the part of the doctor, and so implies no finding of fault.

21 RESTRICTION ON WITHDRAWAL FROM A LIST

21.1 A doctor may not normally withdraw from a list if:

- the Board is considering whether it should refer the doctor's case to the Tribunal or GMC for removal from its Performers List;
- the doctor is suspended from the list; or
- the Board has taken a decision to remove or contingently remove the doctor from its list and that decision has yet to take effect (for example, pending a possible appeal, or pending the outcome of an appeal)

21.2 The only circumstance in which such a doctor may withdraw is with the prior consent of the Department. This prevents a doctor evading a determination by the Board (which would be a matter of record) by voluntarily withdrawing from its list.

22. INVESTIGATIONS

22.1 All Boards should have in place standard procedures for dealing with concerns about a doctor's conduct, performance and competence. The procedures should be flexible and allow for informal resolution of less serious problems.

22.2 Good practice would involve:

- appointing a member of the senior management team (and deputy) to have formal responsibility for taking decisions to suspend, remove or contingently remove a performer from the Board's list (the "case manager"); and
- having a named officer (and deputy) as case-worker and manager of investigations (the "Investigating officer").
- The Case Manager and the Investigating Officer are separate roles and should normally involve different people.

The document "Investigating Performance Concerns" in primary medical services, produced by the Department, provides further guidance on identifying the need for and purpose of an investigation. This document is available at

http://www.dhsspsni.gov.uk/investigating_performance_concerns_guidance.pdf

23. THE INVESTIGATING OFFICER

- 23.1 Ideally the Investigating Officer will be drawn from a small group of staff with suitable experience.
- 23.2 The purpose of the investigation will be to consider whether there are grounds for action against a doctor under the Performers Lists Regulations.
- 23.3 The Investigating Officer:
- should be responsible for conducting any investigations into allegations or concerns about a doctor, establishing the facts on which any decision may be based (including facts that might lead a Board to review or remove a suspension, conditional inclusion or contingent removal);
 - should not be the person who takes the decision to suspend, conditionally include, remove or contingently remove the doctor (the case manager), and should not be able to vary any decision taken under the Performers Lists Regulations;
 - should not be a member of any panel that considers a doctor's representations;
 - should involve suitably qualified and experienced clinicians where a clinical judgement is needed as part of the investigation;
 - should ensure that arrangements are in place throughout the investigation for maintaining confidentiality; and
 - needs to make sure that relevant written statements have been obtained prior to any decision to hold an oral hearing.
- 23.4 The course and nature of an investigation will be a matter for the Investigating Officer. The Investigating Officer's report should contain findings of fact and the case manager should decide on the action to be taken. An investigation in which the facts are already clearly established (such as an adverse GMC or criminal conviction) may well be brief. Other investigations into a doctor's, efficiency or perpetration/involvement in fraud may be complex and time-consuming. The strict rules about fraud

inquiries mean that, where fraud is suspected, the case may need to be referred to Counter Fraud Unit.

23.5 The first job of the Investigating Officer, in consultation with the Case Manager will therefore be to identify the issues:

- the nature of the problem, concern or allegation;
- the likely seriousness of the issue(s) on the basis of the available information; and
- the likelihood of resolving the problem, concern or allegation without need for formal action under the Performers Lists Regulations.

23.6 A preliminary discussion with NPSA, particularly where performance and/or competence issues are involved, may help crystallise the Investigating Officer's first thoughts. Where there are concerns about a doctor in training, NIMDTA should also be consulted straight away.

24 The ROLE OF NPSA

24.1 Poor performance may be the result of health, difficulties in the working environment, behaviour or poor competence, whether in combination or isolation. The processes that NPSA use are directed at addressing each or all of these. Doctors are required to give an undertaking to co-operate with NPSA before they are admitted to a Performers List, and NPSA's ways of working assume that there is a commitment by all concerned to participate constructively.

24.2 NPSA provides a range of help that is focussed on supporting and facilitating the action that Boards may need to take to deal with performance concerns. For example, it can provide:

- immediate, 24-hour telephone advice;
- advice and detailed support for local case management;
- advice and support for local clinical performance assessment;
- advice and detailed NPSA performance assessment; and
- support for implementation of recommendations that result from assessments.

- 24.3 If a Board is investigating whether it should suspend, conditionally include, remove or contingently remove a doctor from its list, an initial approach to NPSA (as noted in paragraphs 5.3 – 5.5) is likely to be productive, particularly in cases involving performance and/or competence issues. As well as helping to crystallise the issues, NPSA involvement may well avoid the need for formal action under the Regulations.
- 24.4 If formal action does prove necessary, the continued involvement of NPSA during periods of suspension, conditional inclusion or contingent removal may help the doctor to overcome the difficulties that led to the action. This may diminish the risk of escalation. However, if it is at all likely that NPSA will be involved, it is preferable for the involvement to begin at the earliest possible stage because it is more difficult to assess a doctor who is not working than one who is.
- 24.5 NPSA publishes guidance on its working methods and on how to refer cases for assessment. This can be seen at <http://www.ncas.npsa.nhs.uk>

25. Involving NPSA during an Investigation

- 25.1 Because NPSA's first involvement in any case will be exploratory, its involvement will give Boards the opportunity to discuss the problems with an impartial outsider and to look at the issues with a fresh perspective. This may lead a Board to appreciate that it can overcome difficulties in ways other than formal action. This may involve consideration of whether problems have more to do with system failure or the environment in which the doctor is working than a doctor's performance or competence, or whether there may be wider problems that need the input of agencies other than NPSA.
- 25.2 Once the problem has been discussed with NPSA, the Investigating Officer, in consultation with the Case Manager, will need to consider whether it can be resolved by means of an informal approach, or whether a formal investigation is still necessary. NPSA can be involved throughout the process whether or not an informal approach is taken. Its involvement may include a formal clinical performance assessment where the doctor, the Board and NPSA agree that it could be helpful in identifying underlying causes of problems and remedial steps that might be taken. Whether or not the issues in an individual case mean that it proceeds to formal action under the Regulations, information from a local investigation may be made available to inform NPSA's work and vice versa.

- 25.3 Because doctors give an undertaking to co-operate with NPSA when they apply to join Performers Lists, failure to co-operate with a referral to NPSA can be regarded as evidence of unwillingness on the part of the doctor to work with the Board to deal with performance or competence problems.
- 25.4 It naturally restricts the options available if a doctor chooses not to co-operate with a referral. Non-co-operation is likely to be a material fact in considering (with other facts) whether to suspend or contingently remove the performer at the conclusion of an investigation.

26. HEARINGS

- 26.1 If a doctor is notified that the Board is proposing conditional inclusion, contingent removal or suspension, and seeks to make a case at an oral hearing, the Board must convene a panel to consider the doctor's representations. Membership of the panel is decided by the Board.
- 26.2 The panel will be most effective if it has the authority to confirm or to change the proposed decision. An alternative would be to convene a panel that makes representations to the Case Manager (see paragraph 22.2), but that is likely to be a less efficient way of operating.
- 26.3 It is open to the Board to involve the LMC in determining the constitution of panels if it wishes.
- 26.4 It would be good practice to vary the composition of panels but not to change the membership completely if a panel is to deal with the same case on a second or subsequent occasion.

27 The Panel's Proceedings

- 27.1 Panel proceedings are for the Board to determine. However, any proceedings should be formal and transparent. The following paragraphs suggest good practice.
- 27.2 Panels ought to have written procedures, which will provide a framework for the decision-making process and help to justify the manner in which decisions are reached.
- 27.3 Panels should not meet in public.
- 27.4 Witnesses who have made statements that may be used during the hearing may be asked to attend. However any decision to call witnesses should rest solely with the Chair, and they ought only to be asked to attend when the Chair is satisfied that their attendance will add materially

to the decision-making process. Witnesses are not under any legal obligation to attend and, generally speaking, their written statements should be sufficient. If a witness is asked to attend it will be to give direct evidence. They may be questioned by the panel, but not by the Investigating Officer or by the doctor who is making representations. The Chair should have an absolute right of adjudication if there is any question about admissibility. If, exceptionally, a witness wishes to be accompanied, their companion will be unable to play any part in the proceedings.

- 27.5 The Investigating Officer will normally put the case for suspension, conditional inclusion, removal or contingent removal. The doctor should then be given the opportunity of making representations. A companion of the doctor's choice may accompany the doctor (who may be a representative of the LMC or a medical defence organisation). However since these are internal proceedings and not a quasi-judicial hearing, there will be no right to legal representation on the part of either the Board or the doctor. Some doctors may prefer to have a legally qualified person present 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. However such a person should not be permitted to question or cross-examine witnesses or address panel members directly.
- 27.6 Except in circumstances when a panel has to be convened at short notice to consider a suspension, it would be good practice for:
- the panel to meet within twenty-eight days of receiving the doctor's representations;
 - the full details of the Board's proposed action (including any written evidence) and its grounds to be sent to the doctor no less than seven days before the date set for the hearing;
 - any late documents to be sent to the doctor as soon as possible, with an offer to put back the hearing, if the doctor wishes, to maintain the seven day principle;
 - an alternative date, within seven days of the original date set where possible, to be offered to the doctor if the Board itself needs to postpone the hearing. Such postponements ought to be necessary only in exceptional circumstances and for good reason; or
 - the panel to have a reserve power to deal with any matter in a doctor's absence if it is satisfied that it had made adequate arrangements to ensure the doctor knew of the

arrangements for the hearing and had failed to attend without good reason.

27.7 If a doctor's ill health prevents a hearing from taking place, the Board ought to consider at what point the doctor is referred to the occupational health service. After a reasonable period, depending on the nature of the incapacity, it should consider holding a hearing in the doctor's absence unless there are compelling reasons for further postponement.

28. Clinical Input

28.1 Relevant clinical input should be provided and presented to the panel if the investigation deals with clinical issues. The input should come from someone with relevant experience of the clinical issues involved, such as a general medical practitioner (with no link to the doctor who is under investigation) or a medical director. An assessment report from an organisation such as the NPSA may also be provided.

28.2 Performance problems of doctors in training should always be treated as training issues. If the investigation involves a doctor in training it would be good practice also to involve the NIMDTA and the Clinical Supervisor from the outset.

29. APPEALS

29.1 Appeals may be made to the Department against the following decisions:

- refusal to include a doctor on a list under regulation 7;
- conditional inclusion of a doctor's name on a list;
- contingent removal of a doctor's name from a list;
- removal of a doctor from a list for not complying with a condition or conditions imposed under conditional inclusion or contingent removal;
- removal of a doctor from a list under regulation 10(1); or
- review and revision of conditions associated with conditional inclusion and contingent removal.

29.2 A doctor who receives notification of these decisions may appeal to the Department within 21 days, or longer period as the Department for reasonable cause allows, from the date the Board notified the doctor of its

decision. The appeal must be in writing and must be sent to the Department, a copy of which shall be sent, at the same time, to the Board. Unless the doctor withdraws the appeal the Department will determine the appeal in accordance with its rules and any directions it may issue about the way in which the appeal will be dealt with. These rules are binding on the parties to the appeal.

29.3 It is in everyone's interests that the appeal process is handled efficiently and with appropriate speed. A doctor involved in an appeal has a justifiable expectation that the process will not be unduly delayed.

29.4 There is no right of appeal against:-

- mandatory removal from a list under regulation 9;
- suspension from a list; or
- a decision to defer consideration of an application.

29.5 Appeals to the Department are re-determinations of the original decision. This means that the Department may make any decision that the Board could originally have made and Boards must implement the decisions.

29.6 Where the doctor's inclusion or continued inclusion on a list is to be subject to conditions the Board will ask if the doctor is prepared to be bound by the Department's decision. The doctor should be allowed 28 days to respond. The Board can agree a longer period if it considers it reasonable. If the doctor does not respond within the period set, the Board can refuse to admit the doctor to its list, or (in a contingent removal case) remove the doctor from its list.

29.7 If the doctor confirms acceptance to be bound by the Department's decision:

- in a conditional inclusion case, the doctor should be admitted to the Performers List subject to the conditions; or
- in a contingent removal case, the doctor should remain on the Performers List subject to the conditions.

In such cases reviews will fall to the Board not the Department.

30. NOTIFICATIONS

- 30.1 It is vital for Boards to share information between themselves, the Department, the NPSA, other NHS bodies, and with any other organisations that employ or contract with a doctor (or might employ or contract with the doctor) if they take action under the Performers List Regulations. Patient safety has to be the overriding concern.
- 30.2 Doctors have no basis on which to try to prevent the sharing of such information by using the provisions of the 1998 Data Protection Act. The Performers Lists Regulations specify the circumstances in which information can be shared. Their effect is that a doctor cannot use Schedule 2 of the 1998 Data Protection Act as a means of withholding consent. The doctor's other rights under the Data Protection Act (such as subject access to information) are unaffected by this.
- 30.3 The Regulations require Boards to share such information whenever they take decisions to refuse admission, conditionally include, remove, contingently remove or suspend a doctor. They must also do so when they review one of those decisions. The Regulations require Boards to send their notifications within seven days of the date on which the decision was taken.

31. Who needs to be informed

- 31.1 The Regulations require Boards to inform the following:
- the Department;
 - other Boards;
 - the Secretary of State
 - the Scottish Executive;
 - National Assembly for Wales;
 - the GMC or any other appropriate regulatory body; and
 - NPSA

It would be good practice also to inform the local LMC.

When the doctor is a doctor in training the Board should also notify NIMDTA.

32. What Information should be shared

32.1 The initial information to be shared should be restricted to the following:

- identifying details of the doctor (name, DOB, NI Number or similar);
- professional registration number;
- date and copy of the decision;
- contact name within the Board for further details; and
- the substance of the decision (this will normally be met by including the words “removed from the Performers List on [date] following a criminal conviction for [.....].” or similar).

32.2 If one of the people or bodies mentioned in paragraph 31.1 seeks further information, the Board may provide it as long as it relates to the evidence it considered in arriving at its decision. It can include the representations made by the doctor. Boards have discretion about the information they provide, but it would be sensible to protect identities by anonymising third party information whenever appropriate.

32.3 The provisions that allow Boards to share such information extend only to matters that the Board considered when making its decision. They do not permit information sharing of issues that may be associated but which the Board did not consider at the time.

33. Notifications to the GMC

33.1 The GMC operates a statutory conduct procedure to investigate and discipline doctors. It may revoke or suspend a doctor’s medical registration or impose conditions on the doctor’s continued practice. The GMC should be supplied with information whenever it would be appropriate to help it to consider whether professional disciplinary proceedings should be instigated.

33.2 Doctors may be disciplined by the GMC for a number of reasons, for example:-

- if their professional performance is seriously deficient;
- if they have health problems but continue to practice whilst unfit;

- when they have been found guilty of serious professional misconduct;
- if they have been convicted of a criminal offence in the UK;
- for fraud; or
- for practising whilst not registered with the GMC.

33.3 This list is not exhaustive. In determining whether it is appropriate to supply the GMC with the specified information, it may be helpful to discuss the matter initially on an informal and anonymised basis with the GMC. Further information is available on the GMC web-site: <http://www.gmc-uk.org/concerns/index.asp>

34. Keeping information up to date

34.1 When a Board has shared information with a third party, it is responsible for keeping the information it has supplied up to date. For example, if a suspension is lifted, or any conditions that were imposed on a doctor's inclusion in the list have been lifted, this is a relevant change that must be passed on as soon as it has occurred. Boards may wish to keep a list of each person or body it has advised of a decision made under the Performers Lists Regulations, so that they can be advised of any change in circumstances.

35. Performers List Notifications and Alert Letters

35.1 The notification procedures set out in the Performers Lists Regulations extend the principles of the Alert Letter system. The Alert Letter system should be used to supplement the notification arrangements in the Performers Lists Regulations whenever necessary.

36. CONTACT POINT FOR QUERIES

36.1 Any queries arising from this guidance should be directed to :

Robert Kirkwood
Primary and Community Care Directorate
Room D3.20
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Phone: 028 9052 0245

E Mail: Robert.Kirkwood@dhsspsni.gov.uk

36.2 This guidance can be accessed on the Department's web site at the following address:-

http://www.dhsspsni.gov.uk/performers_list_guidance.pdf

**CONDITIONAL INCLUSION ONTO THE PERFORMERS LIST –
criteria which a Board should consider**

1. When considering applications for inclusion onto the performers list a Board should consider the following criteria before making a decision to conditionally include a doctor to its list:-
 - The nature of any offence, investigation or incident.
 - The length of time since such offence or incident was committed or since any conviction or investigation.
 - Whether there are other offences, incidents or investigations to be considered.
 - Any action or penalty imposed by any licensing, regulatory or other body (which includes any health service organisation), the police or the courts as a result of any such offence, incident or investigation.
 - The relevance of any offence, investigation or incident to the provision of general medical services by the doctor and any likely risk to patients or to public finances.
 - Whether any offence was a sexual offence to which Part I of the Sexual Offences Act 1997 applies.
 - Whether the doctor has been refused admission to or conditionally included in, removed, contingently removed, or is currently suspended from any Board list or from an equivalent list in England, Wales or Scotland, and if so, the facts relating to the matter which led to such action and the reasons given for such action.
 - Whether the doctor was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate which was refused admittance to, conditionally included, removed or contingently removed from another Board's lists or equivalent list in England, Wales or Scotland, and if so, the facts relating to the matter which led to such action and the reasons given by the Board or equivalent body for such action.
 - whether the doctor is at the time, has in the preceding six months been, or was at the time of the originating events, a director of a body corporate which is currently suspended from such a list, and if so, the facts relating to the matter which led to the suspension and the reasons given by the Board or equivalent body for the suspension.

CONTINGENT REMOVAL FROM THE PERFORMERS LIST

Efficiency grounds

2. When considering the contingent removal of a doctor on efficiency grounds the Board should consider:

- The nature of any incident of conduct which was prejudicial to the efficiency of the general medical services provided by the doctor.
- The length of time since the last such incident (if any) occurred, and since any investigation into that incident was concluded.
- Any action taken by any licensing, regulatory or other body, the police or the courts as a result of any such incident.
- The nature of the incident and whether there is a likely risk to patients.
- Whether the doctor has ever failed to comply with a request by the Board to undertake an assessment by the NPSA.
- Whether the doctor has previously failed to make a declaration or comply with an undertaking required by the Performers List Regulations.
- Whether the doctor has been refused admittance to, conditionally included in, removed, contingently removed or is currently suspended from another Board's list or equivalent list in England, Wales or Scotland, and if so, the facts relating to the matter which led to such action and the reasons given by the Board or equivalent body for such action.
- Whether the doctor was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate which was refused admittance to, conditionally included, removed or contingently removed from another Board's list or equivalent list in England, Wales or Scotland, and if so, the facts relating to the matter which led to such action and the reasons given by the Board or equivalent body for such action.
- Whether the doctor is at the time, has in the preceding six months been, or was at the time of the originating events, a director of a body corporate which is currently suspended from such a list, and if so, the facts relating to the matter which led to the suspension and the reasons given by the Board or equivalent body for the suspension.

Fraud grounds

3. When considering the contingent removal of a doctor on fraud grounds the Board should consider:

- The nature of the incidents of fraud.
- The length of time since the last incident of fraud (if any) occurred, and since any investigation into that incident of fraud was concluded.
- Whether there are other incidents of fraud or other criminal offences to be considered.
- Any action taken by any licensing, regulatory or other body, the police or the courts as a result of any such incident.
- The relevance of any investigation into the incident of fraud to the provision of general medical services by the doctor and the likely risk to patients or to public finances.
- Whether the doctor has been refused admittance to, conditionally included in, removed, contingently removed or is currently suspended from another Board's list or equivalent list in England, Wales or Scotland, and if so, the facts relating to the matter which led to such action and the reasons given by the Board or equivalent body for such action.
- Whether the doctor was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate which was refused admittance to, conditionally included, removed or contingently removed from another Board's list or equivalent list in England, Wales or Scotland and if so, the facts relating to the matter which led to such action and the reasons given by the Board or equivalent body for such action.
- Whether the doctor is at the time, has in the preceding six months been, or was at the time of the originating events, a director of a body corporate which is currently suspended from such a list, and if so, the facts relating to the matter which led to the suspension and the reasons given by the Board or equivalent body for the suspension.

Referral of a case to the Tribunal for removal from a list

4. When considering whether to refer a case to the Tribunal for the removal of a doctor from the list on efficiency or fraud grounds a Board should consider the criteria set out in paragraphs 2 and 3 of this Annex. When considering referring a case for removal on unsuitability grounds a Board should consider:

- The nature of any criminal offence, investigation or incident.
- The length of time since any offence, incident, conviction or investigation.
- Whether there are other criminal offences to be considered.
- The penalty imposed on any criminal conviction or the outcome of any investigation.
- The relevance of any criminal offence, or investigation into professional conduct, on the provision of general medical services by the doctor and the likely risk to patients.
- Whether any criminal offence was a sexual offence to which Part I of the Sexual Offences Act 1997.
- Whether the doctor has been refused admittance to, conditionally included in, removed, contingently removed or is currently suspended from another Boards list or equivalent list in England, Wales or Scotland, and if so, the facts relating to the matter which led to such action and the reasons given by the Board or equivalent body for such action.
- Whether the doctor was at the time, has in the preceding six months been, or was at the time of the originating events a director of a body corporate which was refused admittance to, conditionally included, removed or contingently removed from another Boards list or equivalent list in England, Wales or Scotland, and if so, the facts relating to the matter which led to such action and the reasons given by the Board or equivalent body for such action.
- Whether the doctor is at the time, has in the preceding six months been, or was at the time of the originating events, a director of a body corporate which is currently suspended from such a list, and if so, the facts relating to the matter which led to the suspension and the reasons given by the Board or equivalent body for the suspension.