NHS Resolution

Case studies

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Contents

These case studies are fictional and have been developed to help healthcare organisations:

- See how the Principles for Fairness and Proportionality, and the Framework for consistent, fair and proportionate management of performance concerns, can be applied.
- Reflect on how your use of the framework could support your rationale and decision making where concerns are raised.

The full range of resources relating to the Principles for Fairness and Proportionality and Framework are available on our website.

The case studies are based on the type of cases that Practitioner Performance Advice may be asked to advise on. They draw on the different aspects of case management under local processes, *Maintaining High Professional Standards in the Modern NHS*, The National Health Service (Performers Lists) (England) Regulations 2013 and associated NHS England (NHSE) Policy on Managing the England Performers Lists. They are also consistent with the requirements of *Upholding Professional Standards in* Wales and *Maintaining High Professional Standards in the Modern HPSS.* Each demonstrates how reference to the Principles and Framework may be beneficial in case management.

The case studies deal with different case stages recognising that decisions in some cases need to be taken quickly to protect the safety of patients and staff, including the practitioner. We aim to demonstrate how the framework can be used to take timely action, while ensuring decisions are made on an informed basis, with appropriate consideration of fairness and proportionality.

Through these cases we aim to demonstrate that while the framework may seem at the outset an additional set of steps, the result is a better understanding of what is behind the concerns so they can be successfully resolved to achieve an outcome where the practitioner is more likely to continue to provide quality patient care.

The case studies reference cases being managed by the Medical Director, in some cases delegation of the Case Manager role to a suitably trained individual is appropriate.

Instructions

Please read each case study carefully and consider the different outcomes with and without the use of the Framework, including the impacts on the individual practitioner, their team and patient care. Alternatively, you may wish to discuss these in small groups within your organisation.

CASE STUDY A: Dr Orchid

The concern

An allegation is received by the employer that Dr Orchid shouted at a patient during a consultation and that they threw the patient's hard copy notes across the room as they left the consultation.
As someone involved in the management of the case, consider how the management would be different with and without the use of the framework, and how this may inform your decision making.

Management of the case (without applying the principles and framework)

- Dr Orchid is asked to attend a meeting with their Medical Director - no information is provided as to the reason for the meeting, who will be present, and what procedure or policy is being followed.
- At the meeting, the allegation is shared with Dr Orchid. Dr Orchid is informed that there is to be a formal investigation and told that they will be restricted to non-patient facing duties whilst this is undertaken.
- Dr Orchid is not given an opportunity to respond to the allegation or the restriction to practice.

Applying the Framework

The Medical Director (acting as Case Manager) considers the allegations and utilises the Standards for Fairness and Proportionality Framework. They take the following approach:

<u>Section 1 Ensuring Welfare and Support</u>

Medical Director opts to advise Dr Orchid of the allegation by telephone and:

- Informs them of the allegation, shares that a preliminary review is being undertaken prior to determining next steps and asks them to attend a meeting to provide an initial response.
- Reminds them that they can be accompanied to/represented by someone at the meeting for support, suggests that they seek advice from their defence organisation/trade union (as appropriate).
- Confirms that the preliminary review does not constitute disciplinary action and that no decision has been reached at this point on how the allegation is to be managed.

Dr Orchid's initial response is that "this is something out of nothing", that the patient was just being obtuse and that surely the Medical Director has better things to do with his time.

Medical Director notes Dr Orchid's response, reiterates the date and time of the meeting and reaffirms his recommendation that that they seek advice from their defence organisation/trade union ahead of that meeting and that they can be accompanied.

Section 2 Understanding the Issues

Medical Director holds the meeting with Dr Orchid, who is accompanied by a representative from his trade union.

At the start of the meeting the Medical Director seeks to establish context by enquiring about Dr Orchid's professional background, including their training and induction into the organisation, usual weekly duties and those which they were undertaking on the day of the alleged incident. The Medical Director compassionately asks about Dr Orchid's wellbeing and about any issues/concerns/pressures outside of work

The Medical Director establishes that:

- Dr Orchid is EU qualified and underwent a two-week induction process.
- Dr Orchid feels that they are doing more clinics than their colleagues and that they routinely see 10 patients in a clinic (which is more than the department's standard operating protocol policy permits).
- Dr Orchid feels that that their patient cohort can be particularly challenging and that they rarely have time to take a break during a clinic.
- Dr Orchid has a young child who is undergoing tests for a degenerative disease and that the worry associated with this is causing them sleepless nights. They have not raised this with their Clinical Lead at this point but recognise that this may be impacting on their work.

Section 3 Ensuring the practitioner is heard

Medical Director then seeks a response from Dr Orchid about the specific allegations raised about the patient consultation:

Medical Director establishes that:

- Dr Orchid accepts that they did lose their temper at the conclusion of the consultation and explains that the patient has asked them on numerous occasions during the consultation to prescribe medication which was not indicated for their condition.

- Dr Orchid accepts that they may have raised their voice, telling the patient that they had not been listening to their responses and that the answer would not change no matter how many times the question is asked.
- Dr Orchid recognises that this was unacceptable.
- Dr Orchid adds that the clinic had been extremely busy and was running over its scheduled time. As the patient was leaving the consulting room, they went to close the records folder and reach for the next patient record, fumbled them and the notes fell onto the floor. Dr Orchid suggests that the Medical Director speaks to the nurse that was present for the consultation to corroborate this.
- Dr Orchid discussed why the patient might have perceived their actions in the way that they did.
- Dr Orchid's representative shares their view that this was an uncharacteristic response from Dr Orchid which was a direct consequence of the different pressures resulting from a difficult domestic situation, operational pressures within the clinic and in dealing with the difficult and demanding patient. They add that Dr Orchid clearly regretted their actions.

Section 4 Adherence to Process

Medical Director suggests that Dr Orchid may wish to take some time off work on sick leave, in view of the personal pressures that they've explained. In addition, Dr Orchid is asked to agree to a referral to Occupational Health for advice and support.

Medical Director speaks to the nurse identified by Dr Orchid. The nurse confirms their account.

Medical Director decides that:

- The issue can be resolved informally.
- The allocation of work in the team should be reviewed and asks the clinical lead to do this.
- Following feedback from Occupational Health, Dr Orchid should undertake a stress risk assessment and suggests that they should agree a health security plan with their line manager.
- Dr Orchid should be requested to submit reflective learning on the incident as part of their annual appraisal.

The Medical Director documents all decisions and the reasons for them.

The Medical Director reflects on the following areas of learning for the organisation as a result of what has emerged following application the framework which includes:

- What can be done to ensure work is fairly and transparently allocated across staff in the department, adhering to local policy.
- When planning workload, taking into account which work is more intensive, ensuring staff have sufficient breaks.
- Developing relationships between staff and their managers so they feel able to share information which may have an impact on their performance at work.
- Consider if there are areas in the induction process for staff that could be improved in light of this concern.

CASE STUDY B: Dr Tulip

The concern

The Medical Director is advised that there has been a serious clinical incident involving Dr Tulip, a Consultant in Emergency Medicine. Although full details are not yet available, it is understood that:

- A patient collapsed as a result of an adverse reaction to a local anaesthetic administered by Dr Tulip.
- Dr Tulip has not made a record of the procedure.
- It is not clear whether a medical history was taken.
- It is not clear whether a nurse was present (which would be the usual practise when undertaking such patient-facing activity).

As someone involved in the management of the case, consider how the management would be different with and without the use of the framework, and how this may inform your decision making.

Management of the case (without applying the principles and framework)

The Medical Director (acting as Case Manager) decides that Dr Tulip should be immediately excluded from work on patient safety grounds. Dr Tulip is informed of the decision and is told that it will be reviewed in two weeks, when further information as to the facts are known.

Applying the Framework

Section 2 Understanding the Issues

The Medical Director (acting as Case Manager) undertakes a documented risk assessment in line with Advice's exclusion resources and determines that:

- The level of risk, based on the currently available information, is high.
- They seek information relating to the practitioner's history and is informed that there is no previous history of concerns during their two years employment at the Trust.

The Medical Director reviews the report submitted in relation to the incident and establishes that:

- The Datix report bears Dr Tulip's signature.
- Attached to the Datix report is a handwritten note of the consultation.

- The note references that the patient was clerked by a resident doctor and that there was no recent change to medical history/medication.
- The note also references that a nurse was present and that the collapse occurred before the local anaesthetic was administered.

The Medical Director decides to speak to Dr Tulip to obtain further information relating to the event. This is arranged for the same day.

Section 3 Ensuring the practitioner is heard

The Medical Director meets with Dr Tulip, informing them in advance that they can be accompanied to the meeting by a companion or representative for support and can seek advice from their defence organisation or trade union (as appropriate). At the meeting, Dr Tulip confirms that they have spoken to both their defence organisation and trade union for advice, and is happy for the meeting to proceed based on the advice taken.

The Medical Director establishes that at the time of the clinical incident, the department was at surge capacity with all cubicles, clinical rooms and corridors being utilised to house patients.

Dr Tulip explains that:

- They supervised the clerking and confirmed that the patient did not describe any change to their medical history.
- They can recall that the patient shared that they had been undergoing a number of tests associated with high blood pressure. The patient had also described feeling anxious and having had fainting episodes when their anxiety was at its highest.
- They recognise that a clear instruction was not given to the resident doctor to immediately enter the information onto the clinical records system.
- They prepared for the administration of the local anaesthetic and, having explained to the patient what was to happen, as they approached the patient with the needle the patient collapsed in the chair.
- They called for assistance at this point and a nurse attended to help.
- They recognise that they were not familiar with the requirement for a nurse to be present during patient-facing activity, but adds that this may have been difficult to have facilitated in the circumstances anyway due to the operational pressures.
- They were unable to attend the Trust's induction and in their brief local induction no-one had mentioned this to them.

Section 5 Equity and proportionality

The Medical Director considers the information gathered, including through their discussion with Dr Tulip. They determine that:

- The patient safety risk is lower than first assessed.
- Dr Tulip's induction record should be reviewed, with time provided for them to complete any outstanding activities.
- Dr Tulip should be signposted to sources of support, including the offer of a mentor.
- Dr Tulip should be reminded of the requirement to ensure the patient record is updated contemporaneously and that they sign the record to confirm that they have reviewed it.
- The Datix report should be reviewed in line with clinical governance processes.
- No further action is required in relation to Dr Tulip.

All decisions and reasons for them are documented.

The Medical Director reflects on the following area of learning for the organisation as a result of what has emerged following application the framework which includes:

- Procedures and responsibilities relating to induction, specifically:
    - Following-up promptly with any staff member that is unable to attend their scheduled induction.
    - Assigning a mentor to newly appointed colleagues.

CASE STUDY C: Dr Hibiscus

The concern

Dr Hibiscus's inclusion on the dental performers list for England is managed by NHSE. NHSE are notified by a local hospital that a patient to whom they administered conscious sedation had been admitted to hospital following a seizure. Dr Hibiscus has not responded to telephone contacts initiated by a Professional Standards Case Manager to explore the facts.

As someone involved in the management of the case, consider how the management would be different with and without the use of the framework, and how this may inform your decision making.

Management of the case (without applying the principles and framework)

The case is considered by the Medical Director who is concerned at the lack of contact from Dr Hibiscus and as to the issue more generally. A decision is taken that their dental performers list inclusion should be suspended on public interest and patient safety grounds.

Dr Hibiscus is informed of the decision in writing and:

- Notified they have a right to attend an oral hearing for the suspension to be reviewed.
- Informed that an investigation is to commence.
- Advised of details of the Case Investigator.
- Provided with a copy of the Terms of Reference.

Applying the framework

Section 1 Ensuring Welfare and Support

Further attempts are made to contact Dr Hibiscus. The Practice explain that they are out of the country for two weeks with no access to email and no phone signal.

Section 2 Understanding the Issues

The Medical Director seeks further information relating to Dr Hibiscus 's practise and whether any previous concerns have been managed by NHSE. They establish that:

- Further information is required from the hospital in relation to the clinical incident and the clinical record, including whether the cause of the seizure has been ascertained.
- Dr Hibiscus has previously been under investigation by the GDC in relation to not keeping up to date with sedation practise (as required by national guidelines).

The Medical Director documents their actions and thoughts on a risk assessment. They deem that the immediate risk is low as the practitioner is not currently working.

The Medical Director receives the requested information from the hospital in relation to the clinical incident and the patient's clinical record. This establishes that:

- The seizure was caused by poorly controlled diabetes.
- The sedation does not appear to have been a contributory factor to the seizure.
- The clinical notes are incomplete – there is no detail of informed consent, the dose of sedation or medication used or an account of events.

Section 3 Ensuring the practitioner is heard

Dr Hibiscus returns from leave and contacts NHSE as soon as they are back in the country and have been able to access emails.

Dr Hibiscus is informed that they can be accompanied by a companion or representative to any meeting for support, and that they can seek advice from their defence organisation or trade union (as appropriate).

The practitioner provides their version of events, which are:

- They do not accept that the clinical notes are incomplete.
- They provide relevant CPD information confirming that they are keeping their sedation practise up to date.
- That conscious sedation forms a limited part of their practise and that they do not want to continue to offer this moving forwards.

Section 4 Adherence to Process

The case is reviewed by a decision-making group (Professional Standards Group (PSG)) who consider that whilst it is now known that the sedation was not causative of the seizure, the practitioner's record keeping fell below acceptable standards in this case.

The PSG commissions a records review to inform their decision making.

They agree an Agreement Term that Dr Hibiscus will not provide sedation services pending completion of the records review.

Section 5 Equity and proportionality

Supportive discussions take place in relation to the remediation that the practitioner could undertake whilst the records review is undertaken.

The completed review suggests that there are record keeping concerns which require remediation - the practitioner accepts the concerns, undertakes remediation and provides CPD certificates.

The practitioner confirms they do not wish to provide sedation services in the future.

The decision-making group is assured that remediation has taken place and determines that no further action is required.

The Medical Director reflects on the following area of learning for the organisation as a result of what has emerged following application the framework which includes:

- To consider further whether the practice's management, appraisal and record audits are taking place and to an acceptable standard.

CASE STUDY D: Dr Rose

The concern

Dr Rose is a GP partner in a practice in Wales with four other GPs. Their inclusion on the medical performers list is managed by the local Health Board (HB).
The primary care team at the HB receive a complaint from the family of a patient alleging that Dr Rose failed to visit the patient who then decided to drive to the local Emergency Department. On the way, the patient suffered a cardiac event and crashed their vehicle. Thankfully, the patient survived and no-one else was injured.
Dr Rose's initial response to a call from the HB was limited and defensive.

As someone involved in the management of the case, consider how the management would be different with and without the use of the framework, and how this may inform your decision making.

Management of the case (without applying the principles and framework)

The HB consider the case as part of the initial assessment process and their risk assessment considers that there may be a risk to patient safety. A decision is taken that Dr Rose's performers list inclusion should be suspended on public interest and patient safety grounds.

Dr Rose is informed of the decision in writing and notified they have a right to attend an oral hearing.

Applying the framework

<u>Section 1 Ensuring Welfare and Support</u>

Further attempts are made to contact Dr Rose by the case manager. This includes email and phone calls. Dr Rose does not respond. A message is passed to Dr Rose by the practice manager, but they fail to contact the case manager.

<u>Section 2 Understanding the Issues</u>

The case manager seeks further information relating to Dr Rose including whether there are any previous concerns. They establish that:

- Further information is required from the practice in relation to the request for the home visit and from the hospital where the patient was later admitted after the road traffic collision to clarify the cause of the cardiac event.

- Dr Rose has had two previous complaints against them for not visiting patients. Neither complaint was upheld.
- There is no history of any General Medical Council (GMC) involvement.

The case manager documents their actions and revisions to the risk assessment. They deem that the immediate risk is low as the practitioner is suspended.
The case manager receives the requested information from the practice and the hospital in relation to the clinical incident and the patient's clinical record. This establishes that:

- The patient crashed their car into a tree. They were transferred to hospital by ambulance that arrived five minutes after the crash. The patient did not lose consciousness at any time;
- The cardiac event was caused by elevated blood pressure.
- The patient was initially triaged by phone at the practice by a nurse practitioner who then transferred the call to Dr Rose. Dr Rose then spoke with the patient.
- Dr Rose's notes in the patient record were incomplete – there was no recorded detail of exploration of chest pain or associated symptoms, previous history, or medication review.

Section 3 Ensuring the practitioner is heard

Dr Rose contacts the case manager and explains that they had a family bereavement which has distracted then and prompted the initial short reply. This matter has now resolved, and they are willing to meet. Dr Rose is informed that they can be accompanied by a companion or representative to any meeting for support, and that they can seek advice from their defence organisation or trade union (as appropriate).

Dr Rose provides their version of events, which are:

- They accept that the patient record lacks detail (it is confirmed that they did ask the key questions during the consultation via the recording of the call). They provide mitigation and confirms he has since updated the entry appropriately.
- They provide relevant CPD information confirming that they are up to date on management of cardiac care including attendance at a recent one-day training session.
- That they advised the patient not to drive and to call 999 if they experienced any chest pain or other symptoms.

Section 4 Adherence to Process

The case is reviewed by the Performance Advisory Group (PAG) who consider that the concern is serious. The PAG agree that Dr Rose's record keeping fell below acceptable standards in this case.

The PAG commissions an investigation into the index case and a review of records review to inform their decision making. The HB end the suspension and agree a voluntary undertaking with Dr Rose that they will discuss any cases of a similar nature with a colleague and log these discussions pending completion of the records review and the investigation.

Section 5 Equity and proportionality

Supportive discussions take place with Dr Rose in relation to the remediation that they could undertake whilst the records review is undertaken.

The completed review suggests that there are minor record keeping concerns which could be improved. Dr Rose accepts the concerns and undertakes two record keeping training sessions, a time management course and provides CPD certificates.

The investigation identifies that Dr Rose did ask appropriate questions as part of the screening of the patient. The investigation also finds some areas where the practice could improve in their triage process. Dr Rose agrees to lead on implementation of these changes and agrees to a review by the HB in three months' time.

The PAG is assured that remediation has taken place and determines that no further action is required.

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