**Practitioner Performance Advice (formerly NCAS)**

**Form for requesting the issue of a Healthcare Professional Alert Notice (HPAN) pursuant to The National Health Service Litigation Authority (Amendment) Directions 2019**

This form is to be completed by an Executive Board member or on behalf of an Executive Board member of an NHS Body under the National Health Service Litigation Authority (Amendment) Directions 2019, when requesting the Practitioner Performance Advice service on behalf of NHS Resolution (formerly NHS Litigation Authority) issue an HPAN. Any decisions regarding the request under these Directions will be undertaken by NHS Resolution’s Responsible Officer (RO) or a Senior Practitioner Performance Advice service officer. For further information, please call 020 7811 2600.

To be completed in full and sent to: [hpan@resolution.nhs.uk](file:///C:\Users\munroa\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\X9N2KPWW\hpan@resolution.nhs.uk)

**Incomplete forms are likely to incur a delay before the request is considered**

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| Date of request |  | | |
| 1. **Details of the employer, ex-employer or contractor requesting the HPAN** | | | |
| NHS organisation requesting issue of an HPAN: |  | | |
| Name and position of person requesting an HPAN: |  | | |
| Name of contact (to be listed on the HPAN for potential employers to contact): |  | | |
| Contact e-mail address: |  | | |
| Contact telephone number: |  | | |
| **Details of the Practitioner** | | | |
| Full name of Practitioner: |  | | |
| Sex: |  | Date of birth: |  |
| Ethnicity |  | | |
| Email address (please provide personal email address): |  | | |
| Profession:  Specialty:  Job title: | Medical/Dental/Nursing/Midwifery/Pharmacy/Therapist/Optical professions/Paramedic/Other **(Please delete as appropriate, if other please give details)** | | |
| Professional registration number: |  | | |
| National Insurance (NI) number: |  | | |
| Practitioner’s last known address:  If not known, please check with the relevant regulatory body. |  | | |
| **Reason for requesting HPAN** | | | |
| Reason for request : | Capability/Conduct/Health/Other **(Please delete as appropriate, if other please specify)** | | |
| Description of reason for requesting an HPAN : |  | | |
| Please give details of any relevant advice already obtained by the NHS Organisation in relation to the healthcare professional and details of any restrictions on practice or action taken by the regulator with dates (if known): |  | | |
| Date referred to the Regulator (if applicable):  Note, it is generally expected that this would have occurred prior to the request for an HPAN. | **If not referred to regulator, please give reason** | | |
| Is there additional information available to support the request? | Yes/No **(If yes, please attach)** | | |
| Is there a public or patient safety concern?  (Requirement for an HPAN to be issued) | Yes/No/Not known **(If yes please provide details)** | | |
| Details of other agencies/organisations involved: | None/Police/Other employer/Locum Agency/HEE **(Please provide details, as appropriate)** | | |
| **Practitioner employment information** | | | |
| Is the practitioner still employed by your NHS organisation? | Yes/No **(Please delete as appropriate)** | | |
| If the practitioner is not employed by your NHS organisation, please give date of leaving: |  | | |
| Is the practitioner employed by a locum agency/staffing agency? | Yes/No/Not known **(Please delete as appropriate)** | | |
| If the practitioner is employed by a locum agency/staffing agency or other organisation, please give details: |  | | |
| If the practitioner works for another healthcare organisation, has that organisation been informed? | Yes/No/Not known **(Please delete as appropriate)** | | |
| Does the NHS organisation consider that the practitioner intends or may intend to seek additional or other work in, or for the NHS?  (Requirement for an HPAN to be issued) | Yes/No/Not known **(if yes, please provide details)** | | |
| **Other information** | | | |
| If the practitioner is a doctor, please give the name of their Responsible Officer (RO): |  | | |
| Is the practitioner aware of the request for an HPAN? | Yes/No/Not known **(Please delete as appropriate)** | | |
| Has the case been discussed with the Practitioner Performance Advice Service (formerly NCAS)? | Yes/No **(Please delete as appropriate)** | | |
| If yes, please give case number and name of Case Adviser: |  | | |

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| 1. **For completion by Practitioner Performance Advice Service** | |
| Date of decision: |  |
| **Decision on criteria for HPAN** | |
| Does the practitioner pose a significant risk of harm to patients, staff or the public? | Yes/No **(Please delete as appropriate)** |
| May the practitioner continue to work or seek additional or other work in the NHS as a healthcare professional? | Yes/No **(Please delete as appropriate)** |
| Is there a pressing need to issue an HPAN? | Yes/No **(Please delete as appropriate)** |
| Name of person(s) and/or bodies consulted (if any): |  |
| Additional Information in support of the decision, (Please give details or attach, if applicable): |  |
| **Issue of HPAN** | |
| HPAN to be issued: | Yes/No **(Please delete as appropriate)** |
| Rationale for decision: |  |
| Decision taken by (name and position): | **Name:**  **Position:**  **Signed:** |
| Authorisation by RO/Senior Officer (name and position): | **Name:**  **Position:**  **Signed:** |
| Date of Authorisation: |  |
| Review date (if applicable): |  |

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