Appendix H: FAQ

Frequently Asked Questions

Applications

1. What can we do if we are concerned about a performer's knowledge of English language but they have produced an IELTS certificate?
2. Who can assess the performer's knowledge of the English language?
3. What should we do if the applicant does not have the evidence of sufficient English Language skills?
4. What is acceptable evidence of a performer's intention of providing services in primary care?
5. When can we use the 3-month grace period for applicants?
6. What level of safeguarding training is required for applicants?
7. Does the applicant have to use an accredited SEQOHS occupational health provider?
8. What if an applicant is HIV infected?
9. What information needs to be recorded/retained by NHS England for work permits?
10. How long are blood/serology test results valid for?

Performance Advisory Group

11. Can we have a pre-screening process?
12. What is the definition of 'all complaints or concerns about a named clinician'?
13. How can the PAG consider all concerns when NHS England is not aware of all complaints?
14. When should the performer be notified that there is a concern?
15. Does the PAG have to include a lay representative as a member?
16. What is the definition of a senior manager?
17. What's the difference between fact-finding, information gathering and an investigation?

Appendix H: FAQ

Record keeping

18. Can we use audio recording for PAG/PLDP meetings?
19. Should notes/minutes of the PLDP/oral hearing be verbatim?
20. Will training be provided for minute taking?
21. Are there any templates or standardised processes for clinical record reviews?
22. What information does an Optometrist have to provide to NHS England if they are under investigation by the GOC?

Performers Lists Decision Panel

23. When does the PLDP need to consider applications?
24. Can we have a 'virtual' PLDP meeting?
25. Can the discipline specific practitioner be someone from the Local Representative Committee?
26. What is 'hearsay' evidence and can we admit it?
27. If the practitioner is requesting a witness to attend, do we have to arrange this?
28. Who should sign the PLDP decision letter?
29. Will there be a conditions bank for NHS England?
30. When should a Health Professional Alert Notice be considered?

Financial/Governance

31. Who can make a decision under the Performers List Regulations?
32. When is the performer entitled to suspension payments?
33. How will NHS England ensure the Framework is implemented consistently?
34. How will co-commissioning affect the management of performance concerns?
35. Are PLDP members indemnified?

Appendix H: FAQ

36. Why are the rates of pay for PLDP members set at £50ph?
37. Should PLDP members be paid for travel time?

Remediation/Support

38. How can we access remediation for the performer?
39. Who should pay for remediation?
40. Will there be a standardised induction and refresher scheme across NHS England?
41. Is there a standard definition/requirement for a clinical/workplace supervisor?

Legal Advice/Support

42. How do we access legal advice?
43. When should we access legal advice

Applications

1. What can we do if we are concerned about a performer's knowledge of English language but they have produced an IELTS certificate?

   The Performers' List Regulations (7 (4)(b)) requires NHS England to refuse an application where it is not satisfied that the practitioner has sufficient knowledge of the English language necessary for the work which those included in that performers list perform. This means that the applicant must be able to demonstrate that they can communicate sufficiently to perform primary care services, notwithstanding whether they have produced an IELTS certificate or equivalent.

   If you have concerns about the applicant's knowledge of the English language you should arrange a face to face interview with them to establish whether they are able to communicate effectively within a primary care setting.

Appendix H: FAQ

2. Who can assess the performer's knowledge of the English language?

The test being applied under the Performers' List Regulations is whether the practitioner has sufficient knowledge of the English language to perform primary care services. Where the performer has not studied or trained in the UK, they are required to provide additional information to demonstrate language skills in accordance with the application process.

However, if there are still concerns about the performer's knowledge then you should arrange a face-to-face interview with them to establish whether they are able to communicate effectively within a primary care setting.

The process can be undertaken by NHS staff, for example the Assistant Medical Director or Clinical Advisor, by using a simple set of interview questions based upon common scenarios in primary care. The question to be answered is can the interviewer understand the performer and have a two-way conversation that a patient would be able to understand. The questions and responses should be clearly documented and it would be good practice to have two interviewers in attendance to provide two opinions. NHS England could also refer to the LETB for an educational assessment to include language skills.

If the applicant is required to undertake an oral language test, the cost should be met by them.

3. What should we do if the applicant does not have the evidence of sufficient English Language skills?

It is s requirement that performers must have sufficient knowledge and application of the English language to be able to perform primary care services. Decisions made by the Responsible Officer/Medical Director about the evidence required to be satisfied about the applicant's knowledge of the English language should be made on a case by case basis and be proportionate in all the circumstances. Responsible Officers/Medical Directors may wish to take advice from the LETB.

4. What is acceptable evidence of a performer's intention of providing services in primary care?

The Performers Lists Regulations do not provide a definition for what is considered acceptable evidence and this needs to be determined on a case-by-case basis. It is recognised that some performers may have difficulties obtaining a confirmed position until they are on the national performers list, however they should be able to provide evidence of their attempts to find primary care work. Some examples of acceptable evidence include applications to agencies, application letters for positions or proof of

Appendix H: FAQ

the performer submitting their CVs to potential employers. They do not need to demonstrate that they have been appointed.

5. When can we use the 3-month grace period for applicants?

There are only 3 scenarios where applicants may be afforded the opportunity to start employment pending the processing of their application.

Under Regulation 31 a dental performer cannot provide general dental services unless they are on the performers list. However, this does not apply for the first 3 months if they are undertaking foundation training.

Under Regulation 24(5) A GP Registrar who has applied to the performers list may perform primary medical services for up to 3 months whilst their application is being processed. The 3 months start on the date that they begin the foundation training scheme and they must have submitted their application for consideration.

Under Regulation 39(4) An applicant training to be an optometrist can make an application to the performers list up to 3 months in advance of completing their training to facilitate entry to that list upon successful completion.

Teams must be cognisant of the risk of allowing a performer to provide primary care services pending the outcome of a DBS check.

6. What level of safeguarding training is required for applicants?

- Medical applicants – Level 3
- Medical applicants in training or induction and refresher scheme – Level 2 at point of entry and Level 3 upon completion of training
- Dental applicants – Level 2
- Dental applicants in training with Health Education England – Level 1 at point of entry and Level 1 upon completion of training
- Ophthalmic practitioners – Level 2
- The training should be a recognised, accredited training programme.
- This does not currently cover adult safeguarding.

7. Does the applicant have to use an accredited SEQOHS occupational health provider?

An applicant can use either an accredited SEQOHS occupational health provider or one that is working towards accreditation.

Appendix H: FAQ

All applicants to the dental performers list are required to undertake occupational health assessments to provide with clearance to work within the NHS. General Dental Practitioner applicants will need additional health clearance required for performance of Exposure Prone Procedures as this forms part of their everyday work.

Ophthalmic practitioners are not routinely required to obtain occupational health clearance unless they are providing an enhanced service.

8. What if an applicant is HIV infected?

Following revision of the UK Advisory Panel guidance on HIV infested healthcare workers it is recommended that HIV healthcare workers can carry out exposure prone procedures on the condition that that they are under treatment, which includes regular testing of their viral load, which remains under a threshold level, and they are registered on the UKAP-Occupational Health Register, held by Public Health England. A web based register will be in place by the end of the year but in the meantime UKAP have set up an interim register.

Performers seeking registration on the national performers list who are HIV infected, should be signposted to a number of specialist occupational health departments who have experience in dealing with HIV infected health workers. NHS England may fund appropriate occupational health assessments and associated costs for performers who wish to return to the NHS Performers list with the intention of providing NHS care. A list of specialist OH departments is available on request. – please contact england.primarycareops@nhs.net

9. What information needs to be recorded/retained by NHS England for work permits?

The need for NHS England to record the date that a work permits expires is no longer necessary. NHS England, must on an application to join the List satisfy itself that at the time of the application being considered, the applicant was eligible to perform services and it remains appropriate to check the work permit for this reason. Employers remain responsible for assuring themselves that an employee is allowed to work during the period of their employ.

10. How long are blood/serology test results valid for?

This should be considered by the Occupational Health provider based upon the applicant's role and responsibilities and whether the previous results were sufficient to confirm the level of immunity.

Appendix H: FAQ

Performance Advisory Group

11. Can we have a pre-screening process?

No. The Framework requires that the PAG 'should consider all complaints or concerns that the Medical Director has been made aware of and that are reported about a named clinician'. The purpose for this is to ensure that there is a consistent approach being taken for considering concerns about performers rather than an individual deciding when further investigation/enquiries should be made.

12. What is the definition of 'all complaints or concerns about a named clinician'?

NHS England receives complaints and concerns about a variety of issues such as appointment availability, attitude of the reception staff, practice facilities. Some of the issues may relate to contractual obligations, however when the concern relates to the attitude, conduct or performance of a named clinician these should be considered by PAG. An example may be a patient complaining about a doctor shouting at them or a dentist using inappropriate language causing offence. In itself, as an isolated incident, neither of these examples may give enough cause for concern to warrant intervention. However, they may also be indicative of a practitioner in difficulty for various reasons.

The purpose of PAG considering these is that a pattern of behaviour may indicate a wider concern and/or there may be other information that then becomes available requiring further review.

13. How can the PAG consider all concerns when NHS England is not aware of all complaints?

The Framework requires that concerns or complaints about a named clinician be considered by PAG. The level of review/consideration required by PAG will depend upon the nature of the concern. For example, a relatively low level concern may just be noted by PAG whereas a higher level or repeated issue may result in the PAG instructing further action such as NCAS advice or investigation.

The format in which this information is reported can be in a summary template as long as there is enough information for the PAG to identify the nature of the concern and assess whether any further action is required.

The co-commissioning delegation agreement with the CCGs require any concerns or complaints about a named clinician to be reported to the PAG.

Appendix H: FAQ

14. When should the performer be notified that there is a concern?

The Framework requires the performer to be informed about the complaint or concern 'if appropriate'. This will depend upon the nature of the concern and whether any action is required. For example, it may not be appropriate to inform the performer if it is a low level concern that the PAG decide just needs to be noted. Whereas if further information/action is required then the performer should be contacted. If an investigation is required then the performer must be contacted and provided with the opportunity to respond except in certain circumstances where this may prejudice the outcome such as fraud.

15. Does the PAG have to include a lay representative as a member?

Yes. The PAG membership is specified in the Terms of Reference and includes a lay member as one of the four voting members. Therefore without the lay member, the PAG is not properly constituted.

16. What is the definition of a senior manager?

The NHS Terms and Conditions Handbook refers to senior staff as pay bands 8 and 9. The Chair of the PAG is a very responsible role and has the casting vote if necessary. This is reflected in the description of the membership requiring a senior manager for both the role of Chair and providing expertise in patient safety and experience.

17. What's the difference between fact-finding, information gathering and an investigation?

Information gathering is collating information/intelligence from available sources about a particular subject. In this context, for example, it refers to gathering information such as Quality Outcome Framework (QOF) reports, complaints history or visit reports. This enables the PAG to decide whether further information gathering is required or whether a formal investigation is necessary.

Fact-finding refers to the exercise of validating information or facts, which may be at the point of a formal investigation or at a previous stage.

An investigation in this context refers to the decision to instruct a process with a clearly defined purpose and scope. The case manager will ask a case investigator to answer defined questions within terms of reference.

Appendix H: FAQ

Record keeping

18. Can we use audio recording for PAG/PLDP meetings?

Yes. The Framework and Responsible Officer Regulations require records to be kept of actions and decisions. This is also required for governance purposes. However, the format of those records is for the Medical Director and/or Chair of the PAG and PLDP to decide. If all parties are content with an audio recording to support notes or instead of written notes, then this will meet the requirement. It should be noted however that an audio record is disclosable to the performer upon request and PLDP deliberations should be undertaken in private.

19. Should notes/minutes of the PLDP/oral hearing be verbatim?

The records of the PLDP and/or oral hearing should be sufficient to accurately reflect the issues under consideration, the discussion and the decision making with its reasons. It does not have to be verbatim or attribute particular comments to individuals. It should record the main points of discussion, points of dispute, from which party and the resulting decision.

20. Will training be provided for minute taking?

There are no current plans for NHS England to provide training for minute taking. The administrative function within each area should be in a position to provide adequate minute or note taking skills. Whilst this is not a junior administrative function, particularly for oral hearings, it should be undertaken by someone who is experienced in note taking. It would not be appropriate to outsource this to a legal firm, as this is not the role of solicitors and does not represent value for money. It is a core administrative function for NHS England.

21. Are the minutes/notes of the meetings disclosable?

The practitioner can request copies of the minutes or notes of the oral hearing or PLDP as part of a subject access request. The deliberations of the PLDP should be held in private but the main issues under discussion and the resulting decision should be detailed in the decision letter.

This information is not disclosable to third parties under Freedom of Information, however it may be disclosed to the relevant parties as part of ongoing action; for example, the regulatory body or First Tier Tribunal.

Appendix H: FAQ

22. Are there any templates or standardised processes for clinical record reviews?

NHS England does not have any plans currently to introduce templates or standardised processes for clinical record reviews, however this is an area being looked at by NCAS.

Where record reviews are required, they should be undertaken using clear professional standards, such as those laid out by the regulatory body or Royal College. If guidance is required, teams should contact their NCAS advisor for advice.

23. What information does an Optometrist have to provide to NHS England if they are under investigation by the GOC?

The PL Regulations require a practitioner to inform NHS England in writing, within 7 days when they become the subject of any investigation by any regulatory or other body. The practitioner must include "an explanation of the facts giving rise to that matter, including those concerned, relevant dates and any outcome; and copies of any relevant documents." (Regulation 9 (2)(j) and (3)(a) and (b))

It is not sufficient to just report that they are under investigation. The practitioner must give more information, which will need to be considered by PAG as to whether any action or enquiry is required by NHS England.

Performers Lists Decision Panel

24. When does the PLDP need to consider applications?

The Framework requires an application to be considered by the PLDP when there is 'information of note or a concern arises' in order for the PLDP to determine whether action is required under the PL Regulations. These applications should be referred to the PLDP clearly identifying the queries or concerns and the PLDP should consider the information and any factors required under the Regulations to determine whether there is an efficiency or suitability issue. An example may be where there is a question over the suitability of the clinical references, any disclosures made by the performer or where there is a question as to whether the applicant has sufficient experience working within primary care.

This decision cannot be undertaken by a clinical advisor or by the Medical Director.

25. Can we have a 'virtual' PLDP meeting?

The Framework requires all PLDP members to be 'present' at the meeting, however it

Appendix H: FAQ

does not define this any further. The ordinary dictionary definition would imply that the PLDP members must be in attendance in a place.

The PLDP are responsible for making significant decisions affecting patient safety and/or an individual's career and therefore their discussions and deliberations must be robust. There may be exceptional circumstances in which the Chair may be satisfied that members can be 'present' via alternative means such as videoconference. This may be possible for example in the case of a time sensitive process such as the review of a suspension decision. Another example may be where there is an application to consider and all parties are in agreement, including the practitioner, about conditions being in place that are straight forward or where it is an administrative decision to remove.

However, these circumstances should be exceptional as it is essential that all PLDP members are equally contributing to the process and robustly reviewing the evidence. This is difficult to achieve unless all members are present in the same environment. Ultimately it is the decision of the Chair.

26. Can the discipline specific practitioner be someone from the Local Representative Committee?

Yes. The Framework requires a discipline specific practitioner on both the PAG and PLDP. They must be appointed in accordance with the job role and person specification. If they can demonstrate that they meet the criteria and have the relevant skills and experience then they can be appointed. However, their role and responsibilities would not be as a representative for the LRC but as a professional from that particular discipline.

LRC members can be co-opted onto the PAG but cannot sit as an LRC member on the PLDP.

27. What is 'hearsay' evidence and can we admit it?

Hearsay evidence is information or a statement that is not directly given in person. For example, medical records are hearsay unless the individual who wrote that entry is giving direct oral evidence to validate that entry or has provided an agreed, signed witness statement.

Hearsay evidence may be admissible in civil and criminal proceedings and commonly are accepted. However, there are no rules of admissibility for the PLDP. Evidence is anything that proves that something is or something has happened and can take many forms. The PLDP should consider any evidence that is fair and relevant giving due weight to that evidence based upon the circumstances of the case and source.

Appendix H: FAQ

28. If the practitioner is requesting a witness to attend, do we have to arrange this?

The PLDP is not a formal court of law or tribunal and does not have the same powers or responsibilities. NHS England cannot compel any witness to attend and where they do attend, their evidence is not being given under oath.

The PLDP should therefore consider what value is being added by their attendance. If having that witness attend would materially add to the Panel's decision making then it should be arranged where possible. Otherwise, where there are issues of dispute, the Panel should deal with them by weighing the evidence that is in front of them.

29. Who should sign the PLDP decision letter?

The PLDP Chair is responsible for ensuring that the meeting complies with due process and the decision-making is robust. The Chair also has the casting vote. The decision letter therefore should be approved and sent out in the Chair's name confirming the decision of the Panel as a whole.

30. Will there be a conditions bank for NHS England?

NHS England recognises that a conditions bank would be helpful to ensure consistency across the process. There are various workstreams looking at how consistency can be implemented including the wording of conditions.

Guidance has been provided in the toolkit and training for PAG/PLDP members. The regulatory bodies also have tried and tested banks of conditions publicly available that are useful to refer to when drafting conditions for a performer.

31. When should a Health Professional Alert Notice be considered?

The Healthcare Professionals Alert Notice Directions 2006 prescribe the circumstances in which these alerts should be requested. The purpose is to notify all NHS bodies where there is a concern that a professional/or someone posing as a professional presents a risk to patient safety who may be seeking work in the NHS.

The Notices apply to all healthcare professionals "who are members of a profession which is regulated by a health regulatory body".

They should be considered where there is a belief that the professional may present a risk of harm to patients, staff or the public and:

- the professional is employed or engaged to provide NHS services, including primary care

- the professional intends or may intend to continue in that role or seek additional or other work in the NHS

For example, where a GP has been suspended from the performers list but there is concern that the GP may seek work in other NHS services.

The Notices can be applied for via the National Clinical Assessment Service via email to hpan@ncas.nhs.uk Further guidance can be found at http://www.ncas.nhs.uk/about-ncas/alert-notices/

Financial/Governance

32. Who can make a decision under the Performers List Regulations?

The PL Regulations refer to the NHS Commissioning Board decision-making and does not go into any further detail as to the governance arrangements.

The Framework however clearly identifies that only the PLDP has the delegated authority to make a decision under the Regulations. This includes all aspects of decision-making under the Regulations including admissions and removals for administrative purposes.

33. How will NHS England ensure the Framework is implemented consistently?

The National Policy Development Group is currently working on a Quality Assurance Programme which will provide assurance to NHS England that the Framework is being implemented consistently. The aims of the QA process is to identify areas that may need further support as well as sharing good practice. A toolkit is also being developed to provide guidance on the process for PAG and PLDP for managing performance concerns. This will include a suite of templates to encourage consistency across the regions.

34. How will co-commissioning affect the management of performance concerns?

NHS England will retain responsibility for the management of performance concerns under the Performers Lists Regulations. CCGs will be required to ensure that there are procedures in place to ensure that all complaints about a named performer are escalated to the NHS England team for their consideration. CCGs may be required to provide input or representation to the PAG process to facilitate discussions and sharing of information.

Appendix H: FAQ

NHS England also retains responsibility for the appraisal and revalidation process and the role of the Responsible Officer.

35. Are PLDP members indemnified?

Yes. PLDP members are performing a decision-making role on behalf of NHS England. They are indemnified for any losses incurred as a result of undertaking that role. For example, if a PLDP decided to remove a performer who then successfully challenged the decision and the performer decided to take legal action for loss of earnings, NHS England would be liable for any losses awarded as opposed to individual PLDP members.

NHS England will not however be liable for losses incurred where a PLDP member has been reckless or negligent; or for situations where loss relates to actions that were taken by a member outside of the context of their role. This is the same as any other insurance arrangement.

36. Why are the rates of pay for PLDP members set at £50ph?

The rates for PLDP members were very carefully considered and included a benchmarking exercise to identify what rates were paid not only across PCTs but also similar roles in other organisations.

The rate of pay was agreed at £50ph as it is equivalent to the rates paid by a number of the regulatory bodies. NHS England could not justify paying PLDP members more than the regulatory bodies pay their panellists who are acting in a judicial role.

37. Should PLDP members be paid for travel time?

NHS England's policy is that travel time is not paid for. The member agreement must be in line with NHS expenses policy. It is recognised that there may be exceptional circumstances and the member agreement does allow for this. However, as a matter of course, PLDP members cannot claim for travel time.

Remediation/Support

38. How can we access remediation for the performer?

Formal remediation packages provided by Health Education England is currently variable across regions. However, this is an area of work that is being looked at and progressed.

Appendix H: FAQ

In the meantime, NCAS can provide support on a back to work action plan and PLDPs or PAGs can consider placements under supervision in larger practices or training practices as part of a voluntary undertaking arrangement or conditions. When considering remediation, PAG and PLDPs need to be satisfied that the issues requiring remediation are clear, that the practitioner is engaged in addressing their deficiencies and the recommended actions are sufficient to address them.

39. Who should pay for remediation?

The performer is responsible for paying for any remediation that may be required in order to ensure that they are fit for purpose for providing primary care services. Cases should be discussed on an individual basis.

It is important therefore that PAGs and PLDPs are proportionate in their requirements for remediation. Their NCAS Advisor will be able to advise on an appropriate remediation programme.

40. Will there be a standardised induction and refresher scheme across NHS England?

From 1 April 2015, there is a standard induction and refresher scheme in place for GPs who have not worked in primary medical services for 2 years or more and for applicants who have no previous NHS experience. NHS England teams should refer to Health Education England for details.

41. Is there a standard definition/requirement for a clinical/workplace supervisor?

There is no standard definition for a clinical or workplace supervisor specified by NHS England and this will largely depend upon the individual case and what is trying to be achieved.

Skills for Care (2007) defined supervision as "an accountable process, which supports, assures and develops the knowledge, skills and values of an individual group or team".

The GMC defines a clinical supervisor as "a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement."

The PLDP and in particular the Medical Director/RO should be satisfied that whoever is appointed as the clinical or workplace supervisor for a practitioner in difficulty is appropriately trained and skilled to be able to address the issues identified. The role of the supervisor in a performance case is to assist the individual to address the deficiencies identified in their practice and, through assessment, facilitate the process for that individual to demonstrate that this has been achieved. Although the

individual performer is professionally responsible for providing the evidence that their areas of development have been addressed satisfactorily, the supervisor is accountable to the Medical Director in terms of reporting. This is a different relationship therefore than the more traditional trainer/trainee.

Legal Advice/Support

42. How do we access legal advice?

Legal advice can only be accessed via the central legal team for NHS England at england.legal@nhs.net following the Legal Requisition Gateway Process. You cannot approach a legal firm directly anymore – even if they are on the panel of approved providers. There should be no use of external firms that are not on the panel of approved providers in any event.

The purpose of this revised process is to ensure a consistent approach across NHS England and that external legal services are being contracted appropriately.

43. When should we access legal advice?

There are many occasions where you may require legal advice on performance cases. However, these should be limited to complex, contentious cases.

Following the training that has been provided for PAG/PLDP members, the development of the toolkit and access to the central legal team for NHS England, the use of external legal advice should become less needed. However, it is recognised that there will be a period of transition as new members familiarise themselves with the processes and Framework.

As reiterated in the training, the purpose of this approach is to maintain the focus on patient safety and provide teams with the confidence to manage performance concerns appropriately, proportionately and fairly.