TOOLKIT FOR MANAGING PERFORMANCE CONCERNS IN PRIMARY CARE
The aim of this toolkit is to facilitate the consistent implementation of the Performers List Framework and Performers List Regulations across NHS England as one organisation. The toolkit provides good practice guidance to complement the implementation of the Framework for Managing Performance Concerns in Primary Care and relevant statutory requirements.
Toolkit for managing performance concerns in primary care

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The National Health Service Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.
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1 Background

1.1 Introduction

NHS England is responsible for managing performance concerns in primary care in accordance with the policy and statutory requirements. The Framework for Managing Performance Concerns in Primary Care (The Framework) was drafted in 2014 and revised for implementation from 1st April 2015. It provides the overriding principles for how NHS England teams should discharge their statutory functions and ensures that concerns are handled in a way that protects patients and the public, maintains high standards and is consistent and fair to performers. It supports the implementation of the National Health Service (Performers Lists) (England) Regulations 2013, as amended (the PL Regulations) and the Medical Profession (Responsible Officer) Regulations 2010 (the RO Regulations) as the main legislative frameworks applicable to this area of responsibility.

1.2 What is the purpose of the toolkit?

Managing performance concerns is complex and no one model or policy will be able to cover all cases. However, a practitioner should be confident that their case will be dealt with fairly and consistently no matter where in England they practice. The aim of this toolkit is to facilitate the consistent implementation of the Framework and PL Regulations across NHS England as one organisation. The toolkit should be read in conjunction with the Framework, PL Regulations and Standard Operating Procedures for primary care contractors.

NHS England provided training to caseworkers and PAG/PLDP members during 2014 to support the implementation of the revised Framework from 1st April 2015. This toolkit has been designed to complement the training programme and provide those who are involved in managing performance concerns with a detailed day-to-day guide. It has been developed as a reference tool covering the various aspects of the process from the initial receipt of a concern through to an oral hearing and formal action under the PL Regulations. It should be used as a tool to support the Framework, RO Regulations and PL Regulations to facilitate the management of concerns fairly and consistently. It does not replace the statutory framework set out in the PL Regulations or the policy set out in the Framework and any inconsistency should be resolved in favour of the PL Regulations and Framework.

The PL Regulations apply to general medical practitioners, general dental practitioners and ophthalmic practitioners. However the principles within this toolkit may also be used to guide the management of concerns for pharmacists.
2 Receiving a concern

2.1 What is a concern?

A performance concern relates to any aspect of a performer’s conduct or performance, which may, or may appear to:

- Present a risk to patient safety
- Undermine the efficiency of primary care services
- Undermine patient and public confidence in the NHS
- Represent a financial risk to the organisation or services
- Represent a significant departure from accepted guidelines and/or professional standards

These concerns may arise from a variety of sources and may present themselves in various ways – poor clinical performance, management or administration that compromises patient care, breaching professional boundaries with patients, colleagues or staff, not complying with professional guidelines or criminal acts.

There may be single or multiple underlying causes for under performance but it is essential that any concerns are acted upon promptly, fairly and proportionately. The majority of concerns are resolved locally and without formal action under the PL Regulations. Research shows that the earlier a concern is identified and addressed, the more likely that a satisfactory and successful outcome will be achieved. It is important therefore to ensure that the process for identifying concerns is robust.

Some concerns also fall into multiple categories and overlap with contractual issues, system deficiencies or team culture. These issues need to be dealt with in partnership with managing the performance concern about the performer in order to ensure that the deficiencies are addressed. It is likely that where significant performance issues have been identified about an individual, that there are also difficulties within the team itself. For details on how to assess a concern see section 3.1.

2.2 What is the Role of the Performance Advisory Group?

The Framework requires that the Performance Advisory Group (PAG) consider all complaints and concerns that the NHS England team and Medical Director is made
Toolkit for Managing Performance Concerns in Primary Care

aware of about a named clinician. The Framework recognises that information may become available to the NHS England team from various sources, which is likely to be discussed with the RO and guidance given on whether it amounts to a concern, or what further enquiries need to be made, pending the PAG meeting. **However, once the NHS England Team is aware of a concern about a named clinician it should be referred to the PAG who has the responsibility for considering and assessing concerns. There should be no pre-screening process.** See Case Example in section 2.8.

The PAG have a vital role in ensuring that performance concerns are identified at an early stage and, where appropriate, action is taken to address them. The PAG should meet, as frequently as required, however it is likely that this will need to be at least on a monthly basis.

NHS England receives a number of complaints and concerns and some of these will not need any action taken by the PAG or may require the performer to be signposted elsewhere for support. **It is essential though that all concerns about a named performer are referred to the same process to ensure consistency.** It also enables the PAG to identify trends, which may indicate a larger concern. For more detail on the practicalities refer to section 2.4 and 2.8.

The Terms of Reference for the PAG is contained within the Framework and provides the main duties and authority for the Group. The PAG cannot institute action under the PL Regulations but can make decisions on any other appropriate action that they believe may be required with the exception of enacting the PL Regulations. These decisions may include referral to occupational health, action planning, remediation, support, undertakings or no action. If the PAG believes that action is required under the PL Regulations, they must refer the case to the Performers Lists Decision Panel (PLDP). The majority of cases will be resolved at an early stage or will be closed with no further action.

The PAG should monitor the progress of cases to ensure that they are being managed appropriately, proportionately and in accordance with due process. Monitoring may include considering how a performer is complying and progressing with an action plan, remediation or support processes and, when a case should be closed. Where delegated by PLDP, it may also monitor adherence to conditions. However, any changes required to conditions or issues with compliance must be referred back to PLDP.

The PAG may also decide that the case needs referring to other advisory bodies such as NCAS, Health Education England or the Local Representative Committees. Decision options are dealt with in more detail in section 3.5.
Key Issue/Point of Note

The PAG is responsible for making decisions on the way in which cases are managed. In practice, the case manager will manage the day-to-day work for the cases and report to the PAG as appropriate. The case manager therefore will gather the relevant information and manage the investigation (if so instructed by the PAG) in between the PAG meetings. Any decision that is required about the management of the case, such as instructing an investigation, referral to PLDP or an external body must be made by the PAG. An exception to this may be however where there is an immediate patient safety issue, which would require escalation to ensure patients or the public are not placed at risk.

2.3 Who should sit on the Performance Advisory Group?

The PAG comprises of 4 members:

- A senior manager with a performance role who Chairs the meeting,
- A senior manager with experience in primary care contracting and/or patient safety and experience,
- A discipline specific practitioner nominated by the medical director,
- A lay member;

The correct constitution of the PAG is essential not only to comply with the requirements of the Framework but also to ensure the effectiveness of the Group, which requires the presence of the first three members to be quorate.

The Chair is a responsible position and should be a senior manager, which is defined as Band 8 or 9\(^1\). Their role in performance will provide the relevant practical knowledge and expertise to the Group about the management of a concern. The Chair also has the casting vote on Group decisions.

The senior manager with experience in patient safety and patient experience can be a representative from the operations, contracting or nursing directorate. Their role is to consider the impact on patient safety in the cases being reviewed and to provide the patient experience viewpoint.

**The discipline specific practitioner** should be nominated by the medical director or may be the medical director himself (for medical cases). Careful thought should be given to the constitution of the Group and how it will practically function alongside the PLDP. The Responsible Officer is accountable under the RO Regulations for ensuring that concerns are acted upon appropriately. The Responsible Officer needs to consider how he is able to fulfil his statutory duties and be accountable to the GMC based upon the membership of the PAG and PLDP. For example, the Responsible Officer may decide to be a member of the PAG so he has an oversight of the management of concerns without compromising either his duties as a Responsible Officer or the independence of the PLDP. He can then nominate an appropriate deputy for the PLDP.

The discipline specific practitioner can be recruited from the Local Representative Committee, however their role is specific to their discipline and not to represent their members. The role of clinical reviewer/investigator should not be undertaken by the discipline specific practitioner PAG member, as this would provide a conflict of interest in relation to deciding how to manage or progress the case.

**The lay member** also plays an important role on the PAG as the representative for the public. Their input provides openness and transparency in the process for the management of performance concerns. Although the lay member does not need to be present for the Group to be quorate, they do carry a vote and therefore it should only be on occasion that they are not at the meetings.

PAG members can appoint deputies, who may provide more flexibility on the management of cases, however the deputies must be formally nominated and also be appointed in accordance with the Framework and Job Roles.

In addition to the four PAG members, the Chair may co-opt other individuals to assist the Group. Examples may include members of the local representative committees or individuals from other Directorates. Co-opted members can provide valuable expertise to the PAG, however they are not voting members.

**Key Issue/Point of Note**

All PAG members should be recruited to the role based upon their ability to meet the skills and experience required in the Job Role.

2.4 What do you do when you receive a concern?

Concerns can come from a number of sources and may be isolated and initially low level. An individual concern may in itself seem low risk, however when taken together with other information available it may become suggestive of a pattern of behaviour.
You should also bear in mind that practice level data may mask performance concerns about an individual. Where concerns are from multiple sources, it is likely to indicate a higher risk and should be investigated further. Figure 1 Sources of concerns illustrates the number of sources that may initiate a concern.

A performer may self-refer either following a recommendation by their defence organisation, a colleague, or the LMC. Clinicians have a professional responsibility to ensure that they can practice safely and should seek help accordingly if there are concerns.

In practice, when a concern is received the Medical Team will consider what information should be gathered to assist the PAG in assessing the concern and any risk arising from it. This is discussed in more detail in section 2.8.

Low-level concerns that may have been identified through the complaints or incident reporting process should be reviewed by PAG to consider whether further action/information is required. The PAG does not investigate the patient complaint itself, as this process is managed separately under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. Appendix A Template for Considering Concerns provides a template for reporting concerns to the PAG that Teams may find a useful format to use.

2.5 What do you do when a concern is raised during an appraisal?

Appraisal, for any performer, is not designed to identify concerns. However, during the
appraisal discussion or following a review of appraisal documentation, concerns may become apparent. This situation is most likely to occur during medical appraisal as a result of the role and responsibilities of the Responsible Officer. The PL Regulations require appraisal documentation to be provided as part of the application process where an appraisal has been undertaken, which could equally apply to dentists or ophthalmologists.

NHS England’s Medical Appraisal Policy makes it clear that the appraiser has a professional responsibility to protect patients and take appropriate action where a colleague’s conduct, performance or health may be presenting a risk to patients. Where an appraiser has identified such a concern, they are required to report this to their Responsible Officer who has a statutory duty to take appropriate action. That action may be supportive, for example where the concerns relate to health, or may require further investigation.

2.6 When do you engage with the performer?

In the majority of cases, early engagement with the performer is preferable. This not only ensures that the process is fair, open and transparent but can also enable early assessment and resolution of concerns. However, we should be sensitive about when to do this. For example, if a low level concern is received via a patient complaint, the performer is already aware of the concern, as they will have been contacted about the complaint. If the PAG are unlikely to take any action, notifying the performer that the complaint is being considered by PAG may cause them unnecessary distress.

There may be other occasions where it would be inappropriate for the performer to be advised when a concern has come in, as informing them may compromise the investigation; for example, where the concern relates to fraud or altering records.

With these exceptions in mind, the Team should contact the performer when the concern is initially received as part of the process of gathering background information for the PAG. It is reasonable to have this dialogue at an early stage and can assist the PAG in their decision making as to the appropriate way forward. The performer should be provided with the details of support that they can access throughout this process including the Local Representative Committee, their defence organisation, practitioner health support programmes.

The PAG should also consider whether it is appropriate to communicate with the performer’s practice and, where applicable, their partners. The practice may be in a position to support the performer and provide important contextual information relevant to the concern. The impact of the process for managing performance concerns may also affect the performer’s own practice which should be highlighted to the practice to ensure patients are not affected.
Key Issue/Point of Note

It is not unusual for a performer’s defence representative to advise them not to engage in discussions with NHS England. This may be due to a lack of understanding or appreciation of the aims and objectives of local resolution and responsibilities under the PL Regulations. A failure to engage on the part of the performer can be a very difficult issue for NHS England to manage and could lead to an escalation to PLDP or the regulator. It is therefore rarely in the performer’s best interest not to engage with the process. This can often be resolved by speaking directly to the defence representative and having an open discussion about what the concerns are and what the NHS England Team are aiming to achieve. This also demonstrates a commitment to being fair, open and transparent.

2.7 How do you respond to someone raising a concern?

A member of staff employed by the performer or a colleague may raise concerns. In these circumstances, the individual reporting may wish to remain anonymous. They may be concerned that they will lose their job or be reported themselves as ‘tit for tat’. Employment legislation requires NHS England to protect certain individuals from suffering detriment as a result of raising concerns. The legislation includes individual contractors within primary care. In addition to this legislation, the NHS Constitution requires NHS England to protect anyone who raises patient safety concerns. NHS England has a duty to ensure that any concerns raised are responded to appropriately, regardless of who has raised them. The motives of those raising concerns should not affect how the issues are responded to. The issues raised should not be taken on face value but should be investigated. If they are substantiated, the motives for raising them are irrelevant. The priority is to address the concerns appropriately.

If an individual raising a concern requests to remain anonymous, NHS England must take reasonable steps to protect their identity. The issues raised should be discussed with the performer to provide them with an opportunity to respond but they should not be informed of the identity of the person raising the concern. Instead, the performer should be assured that the concerns will be properly investigated and not just taken on face value. If the concerns are valid, then the findings of the investigation will be the evidence. The identity of the person raising the concern is then not required.

Sometimes, particularly in a small practice, it is very difficult to protect the individual’s identity, as the performer may know who it is. In these circumstances, the performer should be reminded of their professional obligations regarding raising and acting upon
concerns and every effort should be made to ensure that the person raising the concerns is not subjected to detriment.

**Key Issue/Point of Note**

NHS England owes a duty of care to individuals who raise concerns about patient safety and must take reasonable steps to protect them from repercussions. All concerns should be reviewed and acted upon appropriately.

### 2.8 What do you already know?

When a concern is received the first step should be to consider the nature of the concern and whether there are any other issues relating to this performer that may indicate a higher level of risk or provide an explanation. For example, a concern received about a performer’s behaviour may be explained when seen in the context of ill health. This would require a different approach to issues of clinical competence.

This stage of the process can be described as information gathering, which is different from an investigation. Information gathering enables the organisation to gather information that is readily available to it, such as performance reports, complaints or appraisal information. **Figure 2** provides a checklist of some information that the PAG may find useful to assist in the assessment of the concern. This may not be necessary for all concerns but will facilitate the management of more serious issues.

<table>
<thead>
<tr>
<th>Performance information</th>
<th>Quality information</th>
<th>Contract information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing data</td>
<td>Previous complaints</td>
<td>Contract visit information</td>
</tr>
<tr>
<td>Referral data</td>
<td>Significant events/incidents</td>
<td>Contract performance data</td>
</tr>
<tr>
<td>NHS Choices</td>
<td>Regulatory issues</td>
<td>Details of any breach notices</td>
</tr>
<tr>
<td>QOF performance</td>
<td>CQC reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCG information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appraisal / revalidation information</td>
<td></td>
</tr>
</tbody>
</table>
The Team should take into account any relevant information that is available to it and is a requirement of the RO Regulations. This will assist with assessing the nature of the concern that has been received.

**Case Example**

The Medical Team is notified of a patient complaint that has been received by the Nursing Team. The patient has complained that Dr Jones was dismissive towards her during her consultation informing her that her symptoms were ‘all in her head’.

The Medical Team reviews the information that they have available on Dr Jones in preparation for the PAG meeting. The patient list size is falling without any obvious explanation and there are 3 other patient complaints on file about Dr Jones’ attitude. The Assistant Medical Director reports that she had been informed by a colleague in Out of Hours that one of the District Nurses in the area had complained to her line manager about Dr Jones’ unprofessional manner when she had asked him to visit a patient.

**Discussion**

This case has started with a patient complaint about a GP’s attitude. The relevant team will investigate the complaint in accordance with the complaints regulations. However, the Medical Team need to consider whether there is a performance or health concern here. The information gathered including the movement in the patient list suggests that there may be an underlying performance concern. There may be numerous reasons for this including health issues, alcohol/substance abuse or personal or professional pressures. But the information should be reviewed by the PAG to identify whether further inquiries should be made.

The caseworker should present the information to the PAG in a robust, user-friendly format. The PAG can only assess the concern if they have the relevant information available to them. The submission should:

- Provide key contextual background information
- Outline the main findings of the information gathered
- Clearly summarise the issues being considered by PAG
- Include decision options for the PAG to guide them

**Appendix B:1 Template for PAG Submissions** provides a submission template that can be used to assist with the presentation of the information.
3 Responding to a concern

3.1 How do you assess the concern?

In order to assess a concern, the PAG should consider the information presented, and the nature and the severity of the concerns. At first it may be unclear whether there is an underlying performance concern but it is for the PAG to determine if further enquiries should be made and what, if any, risks to patients exist, pending those enquiries. This may form part of the information gathering process or require a formal investigation to be instructed. Therefore the PAG may request more information to assist their decision making but this should be proportionate to avoid challenges of a ‘fishing exercise’ and to ensure the process is fair.

If the issues are multi-factorial and the PAG require further guidance, they may request advice from the NCAS Advisor to assist them. For a definition of what is a concern see section 2.1.

Questions to consider

- Are there concerns about clinical performance?
- Is it one area of performance such as prescribing or is it wider?
- Are there deficiencies in CPD/Appraisal reports?
- Is there more than one source of the concerns?
- Are there concerns about attitude and/or behaviour?
- Are there any historical issues with this practitioner?
- Is there a physical illness?
- Are there signs of a mental health issue, such as stress or depression?
- Could there be alcohol or substance misuse?
- Does the performer have any additional pressures at work or home?
- Have there been any changes in the work environment?
- Are there any known concerns about the practice/work environment?

Once the information has been considered, the PAG should assess the risk using NHS England’s Risk Matrix. This assessment should be based upon the potential severity and likelihood and will assist the PAG in determining their next steps.
Case Example

The PAG received the following summary of concerns about Dr Jones:

- 4 patient complaints in 12 months identifying attitude and behaviour as key themes
- Reducing patient list size with no obvious reasons (e.g. no changes in practices locally)
- Complaint from a District Nurse about Dr Jones refusing to visit a terminally ill patient
- The Controlled Drugs Accountable Officer has reported that Dr Jones’ prescribing of controlled drugs is a significant outlier
- Dr Jones’ appraisal is out of date and his previous appraisal does not meet the requirements of revalidation
- Dr Jones has been contacted for his response to the concerns. He denied the allegations made by the patients and was verbally abusive to the nursing team when they contacted him about the complaints. He has also failed to respond to the Appraisal Lead’s request to arrange his appraisal.

Discussion

Referring to the risk matrix, the PAG consider the information received. They note that there have been 4 patient complaints to NHS England about Dr Jones in 12 months, which is unusually high for primary care. The Nursing Team confirmed that the complaints had identified concerns about the management of the patients as well as attitude and behaviour. The PAG also note that the patient complaints, prescribing concerns and the failure to visit a patient who was terminally ill could represent ‘mismanagement of patient care – long term effects’ or ‘totally unsatisfactory patient outcome or experience’. They determined that this represented a Severity score of Major or Catastrophic.

Based upon Dr Jones’ response, the PAG determined that the Likelihood was ‘Likely’ giving an overall risk score of 16-20.

In this case, the PAG made the following decisions:

- Consult with NCAS Advisor
- Referral to Occupational health to determine if there is an underlying health concern contributing to the behavioural issues
- Investigation into prescribing practices, management of home visits
and a review of palliative care patients
• Appraisal to be arranged as a matter of priority and consideration to be given to a failure to engage in the process if this cannot be progressed
• To be referred back to PAG with the findings

3.2 What do you do with historical information?

Accurate and complete records are a vital part of managing performance concerns in primary care. Information should be clearly documented and stored securely in accordance with NHS England’s policy on information governance. Performance concerns by their very nature can span a long period of time and robust record keeping is essential to ensure case memory is retained. The question of how far back the NHS England Team should look will be dependent upon the nature and severity of the concerns and it should be appropriate and proportionate to those concerns. NCAS may also be able to assist with historical information as they may have come across this performer previously.

Historical issues usually cannot be re-investigated unless new information comes to light. Historical cases can present particular difficulties where the previous concerns were not robustly managed. However they may indicate a pattern of behaviour that the PAG can consider in assessing the concern. Where the previous concerns have been recorded as being resolved but the current issues are of the same nature, this should be explored with the performer to ascertain whether any underlying contributory factors have recurred. This may include a relapse of health issues as an example.

It is important to use any pattern of performance or behaviour previously identified to inform the current investigation and ensure that the process followed is robust. The performer should be kept informed of this and provided with an opportunity to respond.

Key Issue/Point of Note

NHS England can only act upon information that it is aware of but, under the RO Regulations, it must take account of information and any relevant matters that it is aware of.
3.3 When does information gathering/fact finding become an investigation?

Information gathering normally refers to the initial stages of enquiry undertaken when a concern is received and when information/intelligence is collated from available sources. For example, this may include QOF reports, dental activity information, complaints history or visit reports. Fact-finding refers to the exercise of validating information or facts, which may be undertaken as part of an investigation or at a previous stage.

An investigation is an inquiry with a clearly defined purpose and scope and which goes beyond the initial gathering of information or a fact-finding exercise. In the context of managing performance concerns, a case manager should be appointed who will be responsible for managing the process including instructing an investigator. If not already aware, the performer should be notified at this stage.

The PAG may decide to request a review of records in order to determine whether a formal investigation is required. The record review would be a fact-finding exercise used to identify whether there is a wider concern that requires formal investigation under a defined Terms of Reference. Alternatively, a record review may form part of a formal investigation into wider concerns. For more details on information gathering see section 2.8.

When instructing as part of a formal investigative process, a Terms of Reference should be used to identify the questions being asked on the basis of the concerns raised, the timescales to be reviewed and any sample sizes with methods of selection where applicable.

It should be clear to both the performer and the investigator what is being reviewed. The performer should be provided with a copy of the Terms of Reference and be able to comment on it, however it does not require their approval.

Example

**TOR 1:** investigate the allegations of inadequate and brief record keeping, specifically that Dr Patel’s records do not include details of examinations, management plans or reasons for medication changes

The performer should be provided with the opportunity to review the draft investigation report before it is submitted to PAG. An exception to this may be where serious patient safety issues have been identified during the investigation, which may necessitate a referral to PLDP for immediate action.
3.4 Do you need an investigation?

Based upon the information gathered and the risk assessment, the PAG should decide next steps. If the issues are clear, is this something that can be managed informally, for example by agreeing a local action plan or undertakings with the performer? Alternatively, the PAG may decide this is a low-level concern that can be adequately dealt with by a meeting with the performer and/or a recommendation for them to discuss the issues with their employer/mentor/appraiser. It may determine there is no patient safety or public interest concerns and that no action is required. However, if the issues are not clear but are of sufficient concern, further investigation may be required.

The performer should be informed when the decision has been made to investigate. They should be advised to contact their defence organisation and provided with the contact details for appropriate support that is available to them. The Team should liaise with the practice in relation to the investigation to agree resources required, such as access to records, and appropriate communication with the staff and/or patients. The performer should also be involved in this discussion to reassure them that the investigation will be undertaken as discreetly as possible.

Once PAG have decided to instruct a formal investigation, they should receive updates on developments, ensuring that timescales are being adhered to and where there are any immediate concerns reported by the investigator, that action is taken to address this promptly.

Case Example

The investigator contacts the case manager at the beginning of the investigation raising concerns about infection control processes within the dental practice. He reports re-usable instruments are not being properly decontaminated between patients. The PAG request clarification from the dental member about the level of risk presented. The performer is one of three Associates at the practice. The PAG refer to the Public Health team to quantify the risk to patients and engage with the primary care contracting team regarding a potential breach of contract. They also request liaison with the CQC Inspector and in the meantime, the investigation should continue.

3.5 What are your decision options?

The PAG needs to decide how the case should be managed going forward. This will be dependent upon the assessed level of risk, the information available and, where
applicable, the findings of the investigation. The PAG may decide for example that no cause for concern has been identified or, where there has been a single concern and the performer has demonstrated that they are willing to address it, no further action is required. Alternatively, the concerns may be more serious but the performer has acknowledged this and is prepared to work with the Team to address them. In this case, the PAG may determine that it would be appropriate to agree an action plan with the performer, which will enable them to monitor progress and ensure improvements are made.

However, if the performer does not acknowledge an identified performance issue or the matters are particularly serious, undertakings would be inappropriate as a way of addressing the deficiencies. Further guidance on action planning, written agreements and undertakings are provided in 3.6.

Figure 3 provides further guidance on decision options for PAG based upon the level of concern. Appendix F – PAG/PLDP Process Overview provides a high level overview of the PAG and PLDP decision process.

Appendix C provides the decision tree developed by the National Patient Safety Agency, which has been adapted for managing performance concerns in primary care.

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**Case Example**

The PAG receive an update on Dr Jones’ case including the investigation report and occupational health review:

- The Occupational Health Consultant reported no physical or mental health issues, although Dr Jones was suffering from stress as a result of the investigation. No adjustments to practice were recommended;
- There was no evidence that Dr Jones was not undertaking home visits to palliative care patients although there were a number of occasions when he did not record the home visit within the patient’s records;
- The investigator reported that Dr Jones has been described by patients and his colleagues as ‘odd’ and although some patients refuse to see him, there are others who will only see him;
- He does not have a good relationship with his partners or the team and often feels isolated;
- Dr Jones’ prescribing of benzodiazepines is outside clinical guidelines in relation to frequency, dosage and quantity. The Drug Addiction Service has raised a number of concerns about this both directly to Dr Jones and to his partners.
**Discussion**

The PAG consider the findings of the report and are particularly concerned about Dr Jones’ prescribing practices. They also discuss the issues relating to his behaviour and whether this was contributing both to his stress and his reported feelings of isolation.

They all agree that action is required due to the patient safety issues apparent as a result of prescribing and record keeping. They are also concerned about the relationship difficulties apparent within the practice team as this can also affect patient safety. They discuss whether the action required is formal or informal.

If Dr Jones accepts that his record keeping is not within the acceptable standards and his prescribing is outside guidelines and is prepared to address these issues, then an action plan or undertakings may be the most appropriate way forward.

However, if Dr Jones does not have any insight into his deficiencies, the case should be referred to PLDP to consider formal action under the PL Regulations.
Figure 3 PAG Decision Tree
3.6 What is local resolution?

Local resolution is where the case is managed and concluded by NHS England without referring to an external body such as the regulator or police. The National Clinical Assessment Service (NCAS) can assist with local resolution. The majority of the cases that are dealt with will be concluded with local resolution. There are essentially two types – informal such as action plans or undertakings, or formal that involves taking action under the PL Regulations. Although the formal action requires notifying third parties, it does not necessarily require the involvement of external bodies such as the regulator. This is discussed in more detail in section 6.19. This section deals with some examples of local resolution that may be considered in managing and addressing performance concerns. The options are not exclusive to PAG as some of them may be used by PLDP as formal action under the PL Regulations.

3.6.1 Action planning

An action plan is an informal method of addressing clinical performance concerns in a structured and measureable manner. It may be appropriate where a concern about clearly identified clinical performance has been raised, which is easily remediable and the performer is engaging with the process. For example, where the concern is low level and may relate to a single area of practice such as record keeping, agreeing an action plan may be an appropriate and proportionate way forward. In order to agree an action plan, PAG must be satisfied that the nature and extent of the concern has been clearly identified. The NCAS Advisor can help with developing action plans.

Where an action plan has been agreed with the performer, the PAG should agree timescales for reporting progress against the plan. The performer should provide evidence that they are meeting the requirements of the action plan, such as training certificates or audits. The performer should understand how long the PAG will be monitoring the case and what is required for sign off and closure of the case. However, if the PAG are concerned that the performance concerns are not being adequately addressed, they should consider further action.

Resources

NCAS Back on Track Framework
3.6.2 Occupational Health

A referral to occupational health may be appropriate where the PAG/PLDP are concerned that there may be an underlying health issue. The performer may have a recognised health problem or as yet undiagnosed one that may be affecting their performance. Occupational health can provide an assessment as to whether there is a health issue affecting patient care and make recommendations on how this can be addressed. However, you need to be clear with occupational health as to what you are asking of them. It is also important to ensure that the occupational health service understand the context in which the health concern has arisen and the performer’s work environment. Referrals to occupational health should only be made as a result of a concern about the performer’s health – it should not be considered as a matter of routine.

Where the performer has a recognised health concern, another or additional option may include asking for their consent to obtain a report from their treating doctor.

**Resources**

NCAS Handling Concerns about Practitioner’s Health

**Case Example**

Dr Smith was referred to Occupational Health as a result of concerns regarding attitude and behaviour. The PAG receive an update following receipt of the Occupational Health report which is presented as a summary rather than the full report. Dr Smith has been diagnosed with depression and recommendations have been made about treatment and a phased return to work. The PAG agree to the phased return to work and recommend a mentor to support Dr Smith. They request that the mentor provide confirmation of engagement with Dr Smith and that unless patient safety concerns become apparent, the discussions and support will remain confidential.

3.6.3 Mentorship

Where a performer has been experiencing difficulties in their personal or professional life, they may benefit from being able to access a mentor. The mentor can help the performer work through their difficulties and explore practical methods of addressing their concerns. A mentorship arrangement is very different to supervision. The purpose
of the mentor relationship is to enable the performer to discuss their difficulties with a colleague in a confidential manner. Mentorship should only be subject to reporting in relation to engagement and not include the detail of any discussions.

3.6.4 Supervision

Where there have been more serious concerns about a performer’s practice, the PAG/PLDP may decide that a period of supervision should be arranged. Supervision provides the PAG/PLDP and performer with a safety net to ensure that patient care is not compromised whilst performance concerns are being addressed. There are various levels of supervision that may be required from weekly/monthly reflective sessions where the performer discusses cases with them, to more intensive daily or side-by-side supervision. Reporting arrangements for supervision needs to be clear to all parties.

Questions to Consider

- Who is responsible for appointing/agreeing the supervisor?
- What is the role of the supervisor?
- What are the key issues that need to be addressed?
- Is an initial assessment needed?
- How frequently should the supervisor and performer meet?
- What are the reporting arrangements? (you may wish to consider a report template)
- What are the requirements that the performer needs to meet?
- What evidence will the performer be asked to provide to demonstrate that they have met those needs?

3.6.5 NCAS Assessment

Where there have been a number of concerns about a performer’s practice but the causes or extent of the concerns are unclear, an NCAS assessment may be useful to identify what those concerns are and develop an action plan to address them. The PL Regulations require a performer to agree to an assessment if required to do so\(^2\). A referral form must be completed detailing the issues that have been identified about the performer and submitted to NCAS to consider the request. NCAS may decide that an assessment is not the way forward. It is therefore important not to incorporate an NCAS

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\(^2\) National Health Service (Performers Lists) (England) Regulations 2013, Regulation 4(3)(e)
assessment in conditions or undertakings and it should be discussed with the NCAS Advisor as an option before discussing with the performer.

3.6.6 Undertakings

Undertakings are essentially a promise given by the performer to address performance concerns or conduct issues. It is not formal action under the PL Regulations but an agreement made between the NHS England Team and the performer about future practice or behaviour. Undertakings may be appropriate where there are moderate concerns that can be easily remedied AND the performer has insight into the concerns. Undertakings may relate to restrictions on the performer’s practice or behaviour, commitments to supervision or further training.

They should not be used as an alternative to action under the PL Regulations, for serious level concerns or where the performer is not engaging. In these circumstances conditions should be considered under the PL Regulations to ensure that it is formalised and that the relevant bodies have been notified. Conditions are discussed in more detail in 6.14.

Although still an informal action, undertakings are more serious than action plans as they relate to a formal agreement between the performer and NHS England Team. If undertakings are breached it is a serious matter and taken as such by the regulatory bodies as well. Failure to comply with undertakings is likely to result in a referral to PLDP to consider formal action under PL Regulations.

Case Example

The PAG receive concerns about how a community pharmacist is delivering enhanced services. Miss Cooper has not been completing the required assessment for emergency contraception services and there has been a notable increase in dispensing errors within the branch. Initial discussions with the pharmacist have identified a lack of appropriate training and a failure to follow Standard Operating Procedures. The pharmacist is not a contractor and therefore cannot be dealt with under the pharmaceutical regulations. The PAG have received advice from the NCAS Advisor and decide to ask the pharmacist to agree to undertakings to include the following:
You will attend training for the provision of Enhanced Services for Emergency Contraception within a timescale agreed with the NHS England Team;

You will complete an assessment of competencies for the delivery of emergency contraception services facilitated by the NHS England Team within two weeks of completing the training;

You will undertake an audit of the Enhanced Service to demonstrate compliance with the Patient Group Directions and submit the findings to the PAG within 6 months;

You will attend Level 3 Child Protection training and provide a reflective log as to how you will apply this learning to the provision of emergency contraception services;

You will maintain a log of dispensing near misses in a format agreed with the NHS England Team to include contributory factors and remedial action to demonstrate lessons learnt. The log will be submitted to the PAG within 3 months for review of progress;

The PAG notify the pharmacist that although the undertakings are voluntary, a failure to comply with them may result in a referral to the General Pharmaceutical Council. However, having identified that the pharmacist is inexperienced and has not been supported, the PAG are anticipating that the undertakings will provide not only some safeguards for patients but also a supportive structured development for the pharmacist.

**Key Issue/Point of Note**

**Remember:** Unlike conditions, undertakings do not form part of the statutory declarations with the regulators or other NHS organisations and therefore may not be sufficient to safeguard patients.

**Key Issue/Point of Note**

Undertakings should be Specific, Measureable, Achievable, Realistic and Timely. All parties should understand what is expected, the evidence required to demonstrate compliance and the consequences of a failure to comply. For advice on how to draft undertakings and conditions, see 6.14.
3.7 When does a health concern become a performance concern?

A performer may be suffering from a physical or mental health condition that has no impact upon their ability to perform primary care services and therefore requires no intervention by NHS England. However, when a health condition becomes such that it may place patients at risk and/or impact upon the delivery of services, NHS England will need to consider whether action is required.

The level and type of intervention will depend upon a number of factors including:

- The nature and severity of the illness
- Whether this a recurrence of an existing condition or a new diagnosis
- Contributory factors – professional and/or personal
- The performer’s insight into their condition and its potential impact

In the majority of cases, the NHS England Team should be able to support the performer by signposting them to appropriate treatment or referring to occupational health or other service. Where the performer is engaging and has insight into their condition, the PAG may only need to undertake a monitoring role. However, where the performer lacks insight into the impact of their condition, the PAG may need to consider more formal action to ensure that the risk to patients and the public is mitigated.

Health concerns should always be managed sensitively, in particular in relation to what information is shared and with whom.

4 Managing a concern

4.1 What is PAG’s role in managing the case?

The role of the PAG is to ensure that cases are managed in accordance with the Framework, to investigate, advise and monitor cases. Most concerns will not require case management, as they will not progress beyond the information gathering stage. Those that require more investigation or intervention will be managed on a day-to-day basis by the case manager.

The case manager should take forward the actions agreed by the PAG on how the case should be progressed and report any developments back to PAG. The PAG Chair should ensure that case updates are provided on a regular basis including a summary of the issues identified, contextual background information and decision options. It is important that cases are proactively managed to ensure patient safety is not compromised but also for the performer. The longer an investigation takes, the greater the risk to patient safety and the impact on the performer.
4.2 How should PAG monitor cases?

Cases require active monitoring to ensure progress is made in identifying and addressing performance and conduct concerns. There are a number of scenarios that will require monitoring including the following:

- Occupational Health
- Action Planning
- Mentorship
- Supervision
- NCAS Assessment
- Undertakings

In these cases the PAG should receive regular updates from the case management team on how the case is progressing and should consider when further intervention or escalation is required. Similarly this will enable the PAG to determine when the case can be closed.

5 Escalating a concern

5.1 When should a concern be escalated/referred?

In most cases section 3.6 should be the first step before involving the professional regulator with the exception of a serious performance/conduct concern that has either resulted in serious patient harm or may seriously undermine public confidence, for example an allegation of sexual misconduct.

However, where local resolution has failed to address the concerns, the case may need to be escalated to the PLDP and/or professional regulator. There may be a number of reasons why local resolution fails; one reason may be that the performer lacks insight. In these circumstances referral to the PLDP or escalation to the professional regulator may be the only option as NHS England has been unable to mitigate patient safety concerns or address the nature of the misconduct. In the event that local resolution has failed and/or where the PLDP have concerns about a fitness to practise issue in relation to a GP, this can be discussed with the GMC’s Employer Liaison Advisor via the Medical Director.

There may also be circumstances where the remediation required by the performer is too wide ranging for NHS England to be able to support locally necessitating the involvement of either the professional regulator or other external body.
5.2 What is the process for referring a case to PLDP or an external body?

When you have decided to refer a case to either the PLDP and/or an external body, both options will require sufficient, detailed information to enable a decision to be made going forward.

The PLDP

In accordance with the Framework, the role of the PLDP is to make decisions under the PL Regulations. Only the PLDP can instigate action under the PL Regulations, with the exception of immediate suspensions, which is delegated to the RO and another Director. In order to take action under the PL Regulations, there are certain criteria that must be met and formal processes to follow to enable the performer to respond to the concerns.

Once a case is referred to PLDP there is a two-stage process (see Figure 4). Firstly, the PLDP will consider the advice and recommendations from the PAG with the supporting material in order to determine what action should be considered and on what grounds under the PL Regulations. Secondly, having made a decision to invoke the PL Regulations and having given the performer notice of the proposed action, the PLDP, possibly in the form of an oral hearing panel, should then determine whether, dependent upon those grounds and evidence presented, what action, if any, should be taken.

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3 The PAG will not be involved in this process where NHS England has imposed an immediate suspension. In these cases the PLDP will usually receive the information directly from the case manager as part of the review process.
At Stage One, the PLDP will need to consider the evidence that has been gathered during the PAG process and evaluate whether, based upon that evidence, action should be considered under the PL Regulations, what that action should be and on what grounds.

For example, the PLDP may consider that the evidence demonstrates a prejudice to the efficiency of the service but that imposing conditions could mitigate such prejudice. In this case, they would consider the allegations arising from the evidence and what
conditions should be presented to the performer that would be suitable. The notice letter should be approved by the PLDP Chair and sent to the performer inviting them to provide written representations or to attend an oral hearing to present their case. **Appendix F – PAG/PLDP Process Overview** provides a high level overview of the PAG and PLDP decision-making process.

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### Key Issue/Point of Note

The first stage of the process is not to **decide** what action to take under the PL Regulations but to agree what case the performer is being asked to respond to. The performer needs to know what action is being considered against him and on what grounds. Using the PLDP to review the case evidence from the PAG in order to inform whether conditions, suspension or removal should be considered ensures that the case the performer is being asked to respond to is clear. The performer is then given the opportunity to present their case to a different PLDP who will be able to consider NHS England’s evidence and the performer’s response.

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### 5.3 When can we access/share information?

The NHS has a statutory responsibility to protect patients and the public and ensure quality of health services. In order to discharge these responsibilities, the legislative framework provides for access to patient information and facilitates sharing information with relevant bodies. The Data Protection Act 1998 provides for the lawful processing of information for medical purposes where it is undertaken by a health professional or a person who owes the duty of confidentiality that a health professional would have, which includes the provision of care and treatment and management of healthcare services⁴. This is also supported by the contractual regulations for each primary care contractor where it is a reasonable request.

There are additional statutory powers provided for the purpose of managing complaints, investigating concerns and acting in the public interest⁵. Where the purpose of accessing or sharing information is for patient safety or in the public interest, generally, the NHS is permitted legally to do so. Patient identifiable information should only be accessed, recorded and/or retained as necessary. For example, where NHS England have instructed an investigation, the investigator will need access to the patient records in order to complete his enquiries. This is necessary for the purposes of protecting patients, the provision of quality services and in the public interest. However, when the investigation

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⁴ Schedule 1 and 2 (5) and 8 (1)(a), (b) and (2) Data Protection Act 1998

⁵ The Medical Profession (Responsible Officers) (Amendment) Regulations 2013, 11.2(b); Health and Social Care (Community Health and Standards) Act 2003; The NHS Confidentiality and Disclosure of Information GMC, PMS and APMS Code or Practice, April 2013
report is considered by the PAG and/or PLDP, patient identifiable information is not necessary and therefore should be anonymised. The case manager and investigator should ensure that the records on file, held securely, include patient identifiers though in order to cross reference back to information and provide the performer with sufficient information for them to be able to refer to the relevant records themselves.

The Information Commissioner has also been clear about the ability to share information between public sector bodies where it is in the public interest. This would include other regulators such as CQC and the professional regulators, as it is in order to fulfil the statutory duties of these public bodies.

6 Using the Performers List Regulations

6.1 What is the role of the PLDP?

The main role of the PLDP is to make decisions under the PL Regulations. It will consider the advice, recommendations and evidence submitted in relation to concerns about performers. It also has overall responsibility for managing applications to the list, which includes new applications to the list. The PLDP will hear the evidence presented to them, make appropriate, proportionate decisions and provide reasons for those decisions. The objectives are the same whether they are considering the first stage of the process under the PL Regulations or second stage decision making with or without an oral hearing.

The PLDP members are heavily reliant on the information that is presented to them, as they can only take into account what is in front of them. The role of the case manager and/or presenting officer is therefore vitally important to ensure that the PLDP are in a position to make the appropriate decision in order to discharge their responsibilities and protect patients and the public. The majority of cases that will be dealt with by the PLDP are non-contentious with few going to an oral hearing.

When considering whether to invoke the PL Regulations, a PLDP may consider it has insufficient evidence, and may request further investigations and report back as necessary.

The overriding principles are to safeguard patients whilst being fair to all parties and ensuring decisions are made in accordance with due process and the PL Regulations. The PLDP are the ultimate gatekeeper whether they are considering an application to the performers list or reviewing a performance case. The primary concern is always patient safety. The grounds for action are the efficiency of the service, the suitability of the performer and fraud. There is more detail on the grounds and criteria for decision-making in section 6.3 and 6.13.
6.2 Who are the PLDP members?

The constitution of the PLDP has been carefully considered to provide the necessary skills and expertise required for this difficult and responsible role. All the PLDP members should be appropriately recruited in accordance with the job roles and person specification in order to fulfil their responsibilities as a member.

There are four voting members for the PLDP.

- The Chair of the PLDP is a lay member who has experience chairing meetings and working within governance structures assessing risks;
- A discipline specific practitioner provides clinical expertise. They must be practising to fulfil this role and although they can be a member of the Local Representative Committee, they are not there to represent their members but as a member of the profession;
- A senior NHS England manager/director who has responsibility for patient safety / patient experience provides balance to the deliberations and ensures that patient safety is incorporated into the decision-making;
- The Medical Director or a nominated deputy provides delegated authority and responsibility for NHS England;

Deputies should be nominated in advance and appointed in accordance with the Job Role and Person Specification. Deputies may be from a neighbouring team.

All PLDP members should be provided with a formal letter of appointment and sign the membership agreement as appropriate.

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**Key Issue/Point of Note**

All PLDP members must be present for the meeting to be quorate. Virtual PLDPs should only be held in exceptional circumstances. This is to ensure appropriate assessment of the evidence and robust decision-making. If PLDP members are virtual in their presence, the Chair cannot be assured that all members are actively participating in the process. It also makes it more difficult to interact with each other and observe those giving evidence. Exceptional circumstances may be where the PLDP are considering straightforward removals, for example administrative reasons such as a performer who has relinquished their license to practise and does not wish to appear in person to make oral representations.

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6 The membership agreement covers all PLDP members but is also in place for those members who are not employed by NHS England. Those not employed by NHS England must sign the agreement as the formal arrangement between the two parties.
PLDP members must be objective and should not have had previous involvement in the consideration of the case. Therefore the PLDP members who have considered the case at the first stage, that is to decide what action and on what grounds should be presented to the performer, should not be involved in the second stage decision. NHS England teams will need to ensure that they have an adequate number of trained PLDP members to discharge their roles and responsibilities including decisions to immediately suspend a performer. They may, on occasion, need to refer a case to a neighbouring team in which case the performer may need to attend a hearing in another area. For more details on conflicts of interest see section 6.11.

6.3 How do you decide what action to consider and on what grounds?

In most cases, the PAG will have referred the case to the PLDP to decide whether action is required under the PL Regulations. The first stage of this process is to identify, based upon the information/investigation to date, what action should be considered and on what grounds.

There are three grounds under the PL Regulations that action can be considered;

**Efficiency**

The most common ground used is referred to as ‘efficiency’. This entails whether the performer’s conduct or performance may lead to a ‘prejudice to the efficiency of the service’.

Concerns that may fall within this category include poor clinical performance, failure to comply with clinical guidelines, inadequate capability, repeated wasteful use of resources that have not been addressed or actions/activities that have impacted significantly on the workload of others within the NHS. There is no statutory definition of ‘efficiency’ in this context and this ground provides a wide discretion to the PLDP.

**Suitability**

As with efficiency, there is no statutory definition for ‘suitability’ but essentially the question is whether the performer has the ability to provide primary care services. The term ‘suitability’ should be used in its ordinary dictionary definition and may include cases where the performer lacks the appropriate qualifications, experience and essential qualities to provide primary care services. Another example is where the performer has behaved in a way that makes him unsuitable to provide primary care services, such as filming intimate examinations for their own purposes.
Fraud

The definition of fraud for under the PL Regulations is where the performer:

“(i) has (whether on the Practitioner’s own or together with another person) by an act or omission caused, or risked causing, detriment to any health scheme by securing or trying to secure for the Practitioner or another person any financial or other benefit, and

(ii) knew that the Practitioner or the other person was not entitled to the benefit” 7

For the purposes of the PL Regulations, the definition of health scheme includes any service ‘designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of illness’8.

The test to be applied by the PLDP is on the balance of probabilities – whether it is more likely than not that something has happened. Fraud cases that are prosecuted via the criminal route will be tested against the higher criminal standard of ‘beyond all reasonable doubt’. Therefore, if criminal action has not been taken it does not necessarily mean that the case should not still be considered under the PL Regulations. However, the definition of fraud under the PL Regulations does require NHS England to demonstrate intent in that the performer knew that they (or the other person) were not entitled to the benefit. This does not preclude evidence of such matters being included and considered as part of an efficiency or suitability case as an alternative or in addition to.

Key Issue/Point of Note

Suitability and efficiency grounds can often overlap and NHS England can consider action under either or both grounds. However, the imposition of conditions can only be considered an option in efficiency and fraud cases and the only action that can be taken for a suitability case is removal.

Figure 5 illustrates the grounds and actions to be considered at stage one of the process by the PLDP. The options for action will be dependent upon the grounds being considered and the nature of the findings. For example, conditions may be appropriate for either an efficiency or fraud case where they are sufficient to mitigate the prejudice to the efficiency of the service or to prevent fraud. An example may be conditions relating to supervision, monitoring or restricting the provision of service. More detail on this is provided in 6.14.

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7 PL Regulations 14 (3)(c)
8 Section 1 (1) of the National Health Service Act 2006
Toolkit for Managing Performance Concerns in Primary Care

Figure 5 PLDP Considering Grounds and Action

PLDP receive referred case from PAG

PLDP consider the information provided identifying the concerns

Is there an immediate risk to patient safety or the public interest?

Refer to suspension decision flowchart where immediate suspension is being considered

Is it necessary to suspend for the protection of patients and the public or otherwise in the public interest?

Do the findings / concerns suggest that the performer is unsuitable to provide primary care services?

Do the findings / concerns represent a prejudice to the efficiency of the service?

Can the prejudice be mitigated / fraud prevented with conditions?

Can conditions be found that are workable, practical and achievable?

Draft notice letter to performer to include:
- Allegations and Action proposed
- Grounds
- Opportunity to make written representations within 28 days
- Opportunity to put case at an oral hearing if so requested with 28 days

Removal
6.4 How do you write allegations?

The PL Regulations require NHS England to inform the performer of the allegations against him arising from the investigation and/or concerns. The wording of these allegations are important as they clarify the details of the case that the performer is being asked to respond to and the PLDP are being asked to find proved or not. The allegations, supported by the evidence, are therefore the central part of the case. If they are unclear then the process may be unfair for the performer and/or the PLDP will be unable to determine the case effectively.

Where an investigation has been undertaken, the allegations should arise from the findings but may not necessarily be linked to the initial Terms of Reference. The reason for this is that the Terms of Reference directs the questions to be asked and the areas to be reviewed, however findings may then become apparent as a result of the investigation and need to be addressed. For example, the Terms of Reference may have included a review of patient records to ascertain whether the performer is maintaining records in accordance with the required professional standards. However, during the investigation, the investigator may have identified that the performer has deliberately altered the records. This finding will form part of the allegations.

**Questions to Consider**

- What is the basis of the concern, e.g. not following standards?
- Why is this an issue – did the performer fail to do something and if so, what?
- Is there a standard/policy/guideline that sets an expectation about what should be done?
- What is the timescale being referred to and does this need to be referenced in the allegation?
- Where did the incident take place and is this relevant, e.g. was this a home visit?
- Who was involved?
- Does the allegation make clear what we believe the performer has done wrong and why?

Allegations need to be specific and clearly drafted and should avoid the use of adjectives. They do not need to include the word ‘alleged’ though as they will be included in the notice letter as clearly identified allegations.
The allegations need to be supported by cogent and relevant evidence, referenced to any current national or local standards and guidance, and must relate to the grounds (efficiency, suitability or fraud) cited in the notice to the performer.

The PLDP will have to assess whether the evidence supports the allegations as they have been drafted and presented to the performer in the notice letter. It is very important therefore to make sure that the allegations are specific and accurate according to the findings of the investigation.

Figure 6 Example Allegation 1

The allegation in Figure 6 clearly identifies that the performer has not maintained his clinical records and specifically which patient, when and in what way. The evidence to support this should be provided to the performer and PLDP and include a copy of the relevant part of Patient A’s records, anonymised, and the professional standard relating to maintaining clinical records.

Figure 7 Example Allegation 2

The allegation in Figure 7 is not specific enough in that it does not clarify why the behaviour is inappropriate or when it happened. The evidence arising from the investigation should include witness statements and specific examples of the unacceptable behaviour, with whom and when. This information should be used to form the allegation so it is not open to interpretation and the performer understands what is being alleged. An alternative wording would be:

“On or around 18th June 2014, you were verbally abusive towards Dr A, shouting “you are a complete waste of time” or words to that effect.”
6.5 What needs to be included with the notice letter to the performer?

The purpose of the notice letter is to formally notify the performer of:

- The allegations
- The action being considered (i.e. suspension, removal, conditions) and on what grounds (suitability, efficiency and/or fraud)
- The opportunity to provide written representations in response to the allegations and action being considered
- The opportunity to request an oral hearing to present their case in person and how to do so

The letter should also include reference to the relevant regulations that are being relied upon, the date, time and venue and who the PLDP members will be. The notice letter will vary slightly depending upon whether it is for suspension, removal or conditions. The PL Regulations provide for the performer to have 28 days to provide any written representations and therefore it is usually impractical to fix the date of the oral hearing exactly 28 days from the notice.

Key Issue/Point of Note

Identifying the PLDP members in the notice letter enables any questions regarding conflicts of interest to be dealt with in advance, reducing the risk of adjournments at the hearing itself. If however you need to make any changes to panel members or venue, a further letter, can notify these within a reasonable time, without affecting the case.

The letter should be signed by the Chair of the PLDP and sent both electronically, where possible, and by Special Delivery. Special Delivery via Royal Mail is guaranteed, unlike recorded delivery, and proof of receipt should be held on file as evidence that the letter was delivered and when.
The evidence that NHS England intend to rely upon should be enclosed with the notice letter. This provides the performer with the maximum time period under the PL Regulations to consider the evidence.

**Key Issue/Point of Note**

Sometimes additional evidence or issues arise after the notice letter and evidence has been sent to the performer. This may be unavoidable. It is important to provide the additional information to the performer as soon as possible and remind them of their right to provide representations. If the performer or their representative raise an objection to this additional evidence being presented due to the timescales then the PLDP will need to decide whether to consider it. There are no formal rules of admissibility and it will be the decision of the PLDP as to whether it is relevant and fair to all parties to accept the information and proceed, or as an alternative, whether to adjourn.

Template letters are available for the notice letter to include reference to the relevant section of the PL Regulations.

**6.6 How do you record the PAG/PLDP meetings?**

There are a number of ways to record PAG and PLDP meetings, whether this is electronically or on paper. The method of recording is ultimately the decision of the Chair but it must be a robust process to ensure that an accurate record of the meeting is maintained.

Whatever method is chosen, the record should be sufficient to document the decision-making and clearly identify how and why that decision was made. Verbatim minutes are not required and comments should not be attributable to any individual. Any decision made is the decision of the PAG or PLDP and not one individual. PLDP deliberations should be held in private and therefore only the decisions made and the reasons for them should be recorded.

Any notes or audio recordings made are disclosable to the performer upon request.

**6.7 What is the process for an oral hearing?**

When considering action under the PL Regulations, the performer should have been sent a formal notice letter providing him with the opportunity to present written
representations and/or attend an oral hearing. Following receipt of this notice letter, the performer may exercise his right to request an oral hearing and attend, with a representative, to provide a response to the allegations. This is unlikely to be the first time for the performer to respond to the concerns, however this is an important opportunity for them to present their case.

The PLDP Chair is responsible for controlling the hearing and should introduce each stage of the process, for example inviting the parties to present their case. At the beginning of the hearing, the PLDP Chair should also establish the process to be followed by all parties and thereafter ensure that this is adhered to.

It is also useful at the outset of the hearing for the PLDP Chair to establish what matters are in dispute. For example, the performer may agree to some of the allegations but dispute others. If this is the case, by clarifying this up front, it enables all parties to focus on these matters, although the PLDP will still need to take other matters into account when making their decision.

It is important that the PLDP ensure that the performer has been provided with the opportunity to respond to all matters under consideration. If the performer is not represented, the PLDP Chair should take particular care in explaining the process and inviting their response to the issues in question, including the action being proposed.

**Key Issue/Point of Note**

If the PLDP need to consider any issues during the hearing, for example whether additional papers are to be presented or witnesses to be called, they may decide to adjourn for a short period to enable discussion in private. The PLDP Chair controls the hearing and must ensure that the process is fair to all parties.

Appendix E Procedure for Oral Hearing provides an aide memoir for the oral hearing process.

6.8 Who needs legal representation?

The performer is entitled to representation or support, whether this be from a legally qualified representative or a friend/colleague. The process can be very stressful for the performer and a legal representative can often provide valuable support to them and also assist the PLDP in their decision-making by helping the performer with their response. The case manager should clarify with the performer who, if anyone, will be attending the oral hearing beforehand.
If the performer is unrepresented, they may need support/guidance from the PLDP Chair to ensure that they understand the process.

**NHS England** is responsible for presenting the case and this should be undertaken by the case manager who is in a position to answer any questions from the panel or the performer/representative. A legal representative for NHS England cannot advise the PLDP and therefore the question should be asked as to what their role may be. It should only be in exceptional circumstances that NHS England requires legal representation, for example, due to the complexity of the case.

**The Panel** may consider the need for legal representation if the case is particularly complex. It should not be required on a routine basis as the PLDP members should be familiar with the PL Regulations and the Framework. Where a legal representative is present to assist the PLDP members, they can provide advice on process to ensure it is fair, questions of law, evidence or procedure. They can continue to assist PLDP members during deliberations, however it should be a fair, open and transparent process and if additional advice required is significant to the case, parties should be recalled to be provided with the opportunity to respond or comment.

**Key Issue/Point of Note**

It is important to maintain the focus on patient safety. The PLDP is not a legal hearing or a court of law. The PLDP Chair is responsible for ensuring that all parties, including any legal representatives, comply with the procedures set out to enable a fair, effective and efficient hearing.

**6.9 Do you need witnesses?**

Witness evidence may be in the form of a written statement or oral evidence. The purpose of witness evidence is to provide supporting information relevant to the matters in question. This may be in the form of knowledge of a particular matter or event or providing an opinion on an issue, for example the use of clinical guidelines.

Whether witness evidence is required will be dependent upon the facts of the case. It is important to remember that NHS England have no powers to compel a witness to attend an oral hearing and witness evidence is not given under oath. Therefore, whether oral evidence is required will depend upon how significant it will contribute towards the decision-making.

Where an investigation report has been commissioned, the investigator may have already obtained witness statements as part of that process and the performer will have been provided with the opportunity to question, dispute or challenge those statements.
The performer’s response to these should be made evident to the PLDP and any challenges should therefore be clear prior to the oral hearing along with NHS England’s response. The question to be asked is what additional value will be added by their attendance?

Questions to Consider

- Who is the witness being called?
- Have they provided a witness statement?
- Are there matters in dispute within their witness statement?
- Is their evidence relevant to the matters in question?
- Are they witnesses of fact, experts or providing testimonials?
- Will their attendance materially add to the decision making process?

*NB. Patients should only be asked to attend as a witness in exceptional circumstances*

6.10 What is evidence and how do you assess it?

Evidence is essentially anything that reasonably demonstrates that something is or something happened. There are no rules of admissibility. The PLDP should consider whether the relevance and voracity of the evidence. The PLDP will be required to assess the evidence presented to it, what weight to give the evidence and act in a manner which is fair and just to all parties.

Evidence may be presented in various forms:

- Medical records
- Policies or procedures
- Written statements
- Oral testimony
- Transcribed interviews
- Written records such as letters, memos or reports
- Inspection/investigation reports

Questions to Consider

- In what form is the evidence – written or oral?
The questions in the table above will assist the PLDP in considering what weight to give to the evidence presented. Written, contemporaneous evidence is likely to be more reliable for example than oral evidence provided some time after the event. However, written evidence, such as medical records, may also be particularly brief whereas oral evidence may be more helpful as it allows the information to be expanded upon depending upon the timescales and circumstances.

The reliability of the source is not necessarily the same as credibility as there may be other influencing factors. For example, a patient’s account of a consultation may be affected by their lack of understanding of the medical issues but this does not necessarily affect the credibility of their account.

Some of the evidence that the PLDP will receive may be opinion – for example, the case investigator commenting on whether a treatment plan was appropriate, which may be based upon the relevant clinical guidelines and/or the expertise of the case investigator. Whereas some evidence will be factual, for example whether the doctor prescribed a particular drug. Opinion evidence is not necessarily less reliable than factual evidence, however it is often easier to assess due to its nature.

**Key Issue/Point of Note**

Hearsay evidence refers to an oral or written statement/information, which is not given first hand on oath during the proceedings in question (sometimes described as ‘direct evidence’). Oral hearsay evidence would be a person giving an account of what some other person was heard to say on an earlier occasion. An example of written hearsay would be medical records unless the author is providing direct oral testimony. Hearsay evidence is routinely accepted in both civil and criminal proceedings in the UK. The question to be
considered by PLDP members is not whether the evidence is hearsay but what weight the evidence should be afforded.

6.11 How do you manage conflicts of interest?

The common law position on conflicts of interest has been that where the decision maker has a pecuniary or proprietary interest in the case, they should not be involved. The basis for this is that decision makers should be open minded, independent and without bias. The performer is entitled to an impartial hearing and the public should be able to have confidence that the process is fair and robust.

The constitution of the PAG and PLDP, particularly the lay member role, provides an element of structural independence for NHS England. Members should be able to demonstrate unbiased decision making with any challenges to conflicts of interest being dealt with robustly. For example, the discipline specific practitioner for PAG should not be involved in the investigation of cases as well as the evaluation/consideration of how to manage these cases.

Legal challenges of actual bias are rare, however the appearance of bias is regularly considered where there is a connection between the decision maker and someone else involved in the proceedings. When challenges are made about conflicts of interest, the test applied is whether the fair minded and well-informed observer would consider that there is a real possibility of bias in the decision-making. The fair-minded observer is considered to be someone who is not overly suspicious or too trusting and who is conversant with the facts and circumstances of the case. There is also allowance made for an element of professionalism, in that the fair-minded observer would expect decision makers in these circumstances to act in a professional manner, notwithstanding any personal bias. In other words, they would be expected to uphold their professional standards and ethics when considering a case.

There is a distinction between the appearance of bias and predetermination on the part of the decision maker. Decision makers may be predisposed to a particular viewpoint for example because they have received the evidence bundle but not yet heard all of the evidence. It may be that they have not heard the performer’s response and this may lead to an element of presupposition. However, they must not predetermine their decision. This is particularly important when undertaking a review of a suspension decision in that the PLDP members need to ensure that they are open minded about the case and have not predetermined the outcome because of the previous decision makers.
Most conflicts of interest arise either from a relationship/acquaintance with one of the significant parties involved in a case/decision, or a particularly close connection to some of the facts of a case/decision.

There are two aspects that PAG and PLDP members need to be conscious about – firstly the appearance of bias and secondly that they have an open mind about the case.

6.12 When should you adjourn?

There are a number of circumstances in which an adjournment may be requested and/or considered. The performer may be requesting an adjournment to allow further time to consider the evidence or prepare their case. They may be unable to attend the hearing due to ill health or prior commitments. Alternatively, it may be the PLDP who require a short adjournment to consider a key issue that has arisen or read evidence that has been presented by the performer.

Questions to Consider

- What is the reason for the adjournment?
- If the performer is asking for more time, how much notice has been provided and is it reasonable?
- Is there a health issue given as the reason for an adjournment, if so, is an occupational health referral or correspondence from the performer’s
GP required?

How much time is needed for the adjournment, obviously a brief one to enable papers to be read will not be as problematic as adjourning for a hearing at another time?

Are there significant patient safety issues that may be affected in the event of an adjournment to another date/time? If so, can/do these need to be addressed with voluntary undertakings or by an extension to an existing suspension (bearing in mind the 6 months limitation)? Do you want to consider ‘un-suspending’ the performer if the illness is likely to last for a significant period of time, which might jeopardise your 6 month limit?

It is the PLDP’s decision whether an adjournment is allowed or arranged. The PLDP should consider the issues in question, whether they represent a patient safety risk and fairness to all parties. It is clearly in everyone’s interests for the case to be progressed and decided upon promptly. The PLDP should satisfy themselves that the performer has been provided with adequate time to consider the evidence and respond to the case against him. If this is not the case, then an adjournment may be required to ensure that the performer is in a position to have a fair hearing.

Case Example

Miss Williams, a dental performer, contacts the NHS England Team on the morning of the oral hearing to advise that she is too ill to attend. She has been to see her GP who has provided her with a medical certificate due to stress and has requested that the oral hearing should be delayed until she feels well enough.

The PLDP receive the request. They ask NHS England if the performer has been referred to occupational health. NHS England advises that a referral has not previously been made although it was offered to Miss Williams at the outset of the investigation.

The PLDP are concerned that the case involves patient safety issues and that proceeding with the case would be in the public interest. They note that they do not believe that the threshold for suspension is met in this case, based upon the information they have available to date. However, they are also concerned that Miss Williams may not be well enough to represent herself at an oral hearing. NHS England confirms that the medical certificate has been scanned and emailed, confirming that Miss Williams has been
signed off for 4 weeks. The PLDP agree to the adjournment on the following basis:

- Patient safety will not be at risk whilst Miss Williams is off sick
- Miss Williams must not return to work without notifying NHS England who may require undertakings pending another oral hearing being arranged
- Miss Williams will be referred to occupational health for an assessment to include any support that she may require
- Miss Williams will be signposted to other support services who may be able to assist her during the performance process

6.13 What decision options do you have?

The PLDP have a number of decision options, including taking no action at all. Decisions that can be made under the PL Regulations are:

- No action
- Suspension
- Conditions
- Removal
- Refusal to include

The PLDP will initially be required to assess the case to identify what action should be considered under the PL Regulations and on what grounds. This is explained in section 6.3.

At stage two, the PLDP should firstly consider all representations, whether oral and/or written, from both parties. Having taken representations into account there are additional criteria that they must also consider based upon the grounds of suitability, efficiency and/or fraud as illustrated in Figure 8.

There are a number of requirements under Regulation 99 that the performer is required to comply with, which the PLDP may need to take into account during their decision-making.

- Declaring criminal convictions, becoming subject to investigations or where the outcome of an investigation is adverse or has lead to action taken under a list

9 Regulation 9 Requirements with which a Practitioner included in a performers list must comply
• Declaring any involvement in any inquest as an ‘interested person’ or someone whose conduct is likely to be called into question
• Making any such declarations in writing within 7 days including providing an explanation of the facts involved, relevant dates and copies of any relevant documents
• Participating in appraisal systems
• Complying with conditions imposed on inclusion to the performers list

Failure to comply with these requirements and/or concerns arising from any declarations made should be considered by the PLDP when deciding on any appropriate action, if any, to take.

The length of time since the incident or event took place may impact upon the risk to patient safety or the public. For example, if it was a performance concern that occurred some years ago but there have been no incidents since then the PLDP may make a different decision than if the incident had recently occurred.

Although the PLDP are not held to any decision taken by either the regulator or any other body, they are factors that should be taken into account. The test to be applied by NHS England is different to those considered by other bodies. This is discussed in more detail in section 6.19.

The PLDP should also consider the relevance of the matter to the provision of primary care services. For example, if a performer had been convicted for displaying a fraudulent tax disc, the PLDP is less likely to take as serious action compared to a performer who has made fraudulent claims for the provision of services. However, the public interest and suitability of the performer would still need to be assessed and therefore the fact that the incident is not directly relevant to the provision of primary care services does not mean that no action is required.

<table>
<thead>
<tr>
<th>Suitability</th>
<th>Information under Regulation 9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any information available from the NHSLA</td>
</tr>
<tr>
<td></td>
<td>The length of time since the event and what the facts were behind the event</td>
</tr>
<tr>
<td></td>
<td>Any action taken by the regulator or other body</td>
</tr>
<tr>
<td></td>
<td>The relevance to the provision of primary care services including patient risk or public finances</td>
</tr>
<tr>
<td></td>
<td>Whether the event was a sexual offence</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Information under Regulation 9</td>
</tr>
</tbody>
</table>
Key Issue/Point of Note

Don’t forget the additional discipline specific criteria in the PL Regulations including Regulations 27 and 28 for medical, 34 and 35 for dental and 40 and 41 for ophthalmic.

The PLDP may also consider other action not under the PL Regulations. These options may include:

- **Action Planning**
- **Referral to Occupational Health**
- **Mentorship** arrangement
- **Referral to consider an NCAS Assessment**
- **Undertakings**
- **Referral to an external body, regulator or back to the PAG**

These options are discussed in more detail in section 3.6 and 6.19.
6.13.1 Suspension

The criteria for considering suspension is whether it is ‘necessary to do so for the protection of patients or members of the public or that it is otherwise in the public interest’. The purpose of a suspension is to enable NHS England to continue with their investigations/enquiries whilst also protecting patients and the public in the meantime. It is a ‘neutral act’ in that few if any facts will have been clearly established at this point and therefore the decision is taken on the basis of risk. The PLDP will probably not have much information or evidence at subsequent stages of the suspension process. Appendix D Suspension Flowchart provides a decision flowchart for suspensions including the timescales and decision-making process.

The PL Regulations specify the maximum timescales for suspensions based upon the reason for the suspension as illustrated in Figure 9. If the suspension is imposed to enable NHS England to complete their investigation whilst deciding whether to impose conditions or remove the performer, the maximum aggregate period of suspension is 6 months. This period cannot be extended. If NHS England is awaiting the outcome of a criminal or regulatory investigation or decision the maximum period is 6 months. However, they will be able to apply to the First Tier Tribunal for an extension to the 6 months aggregate.

<table>
<thead>
<tr>
<th>Question</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you deciding whether to exercise powers to impose conditions or remove from NPL? Reg 12(1)(a)</td>
<td>➔ Maximum period 6 months ➔ No extension permitted</td>
</tr>
<tr>
<td>Are you awaiting the outcome or decision of a court or regulatory body/investigation? Reg 12(1)(b)(i) and (ii)</td>
<td>➔ Maximum period 6 months ➔ Can apply to First Tier Tribunal for an extension</td>
</tr>
<tr>
<td>Has the performer been suspended on an interim basis by their regulator? Reg 12(1)(A)</td>
<td>➔ Remains in effect until either the interim suspension order is revoked or NHS England decides to remove</td>
</tr>
<tr>
<td>Has the performer been suspended on an interim basis by their regulator? Reg 12(1)(A)</td>
<td>➔ Remains in effect until appeal is disposed of or decision made by NHS England</td>
</tr>
</tbody>
</table>

Figure 9 Periods of suspension
**Proactive and timely case management following a suspension is essential.** This is particularly so where it has to investigate, service the evidence (with 28 days minimum notice) and conclude any hearing within the 6 months period. NHS England should not necessarily be relying upon the decision of another body before considering the case (unless it is an active police investigation or criminal prosecution), as the criteria and tests to be applied are significantly different.

A suspension should be kept under continuous review and should be revoked by NHS England at any time where it is considered that it will not compromise the protection of patients, members of the public or the public interest.

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**Case Example**

Dr Long is a GP Registrar who has been accused of inappropriate contact with a patient. The patient has reported him to the police who are investigating it as a criminal matter. The GP Tutor reports that he has received concerns from two other patients about Dr Long’s overtly sexual manner during consultations but no formal complaint had been made. The complainant’s extended family are all patients at the practice as well.

The PLDP are asked to consider a suspension on the basis that it is necessary for the protection of patients and that it is in the public interest. NHS England submits that this is necessary for the following reasons:

- The allegations are of a serious nature relating to sexual offences and suspension is necessary to protect patients and members of the public.
- Dr Long is a GP trainee and was under supervision when the alleged offences occurred.
- The public interest would not be met by any restrictions of practice other than suspension.
- Suspension would also be in the interests of Dr Long as it would remove him from the working environment.

PLDP consider the risks to patients and members of the public that may be presented as a result of the allegations. Whilst no findings of fact have been made, the PLDP are concerned that there is a risk that the complaint may not have been an isolated event and that the GP was a trainee when the reported incident occurred. It also relates to a sexual offence.

The PLDP decide to suspend Dr Long under Regulation 12 (1)(b)(i) whilst it awaits the outcome of the criminal investigation. The period of the
suspension agreed is 5 months, to be reviewed in 4 months to enable NHS England to report progress on the police investigation and, should the suspension period need extending, allows time to apply to the First Tier Tribunal. In the meantime, the PLDP request assurance from NHS England that they will liaise with the police and the practice to facilitate proactive management of the case. NHS England reports the decision of the PLDP to Health Education England and to the employing body in addition to the statutory requirements under the PL Regulations.

6.13.2 Conditions

Conditions may be considered appropriate in order to prevent any prejudice to the efficiency of the services or for the purpose of preventing fraud. Conditions cannot be imposed for suitability cases.

The PLDP must first determine that there is a prejudice to the efficiency of the service or that the performer has committed fraud. They should then consider whether conditions could mitigate any prejudice or prevent fraud.

Key Issue/Point of Note

The PLDP should consider what conditions may be appropriate at Stage One and include these in the notice letter to the performer. This does not prevent the PLDP amending them at Stage two but the performer should have the opportunity to respond to what is being proposed.

Remember: the performer must agree and give an undertaking to comply with the conditions at the stage of inclusion (and if he doesn’t then the application must be refused and the performer notified of the reasons and his right to appeal).

Conditions must be Specific, Measurable, Achievable, Realistic and Timely. The performer is required to provide evidence of compliance and the clear wording of the conditions is very important. This is discussed in more detail in section 6.14.

When considering whether conditions are appropriate, the PLDP should take into account whether the performer has shown insight into the issues. For example, has the performer, upon reflection, recognised or demonstrated that they would have acted differently if the situation were repeated. This is not necessarily the same as the performer admitting liability for an error but is an important factor as to the likelihood
of conditions being effective. If the performer has not shown insight, conditions are less likely to be successful in addressing any deficiency.

6.13.3 Removal

There are mandatory grounds for removal and discretionary grounds under the PL Regulations as illustrated in Figure 10. There have been amendments made to the 2013 PL Regulations where a performer has been suspended on an interim basis by their regulator in that this is no longer a mandatory ground for removal.

<table>
<thead>
<tr>
<th>Mandatory</th>
<th>Discretionary</th>
</tr>
</thead>
<tbody>
<tr>
<td>➣ Conviction for murder in the UK</td>
<td>➣ Conviction of criminal offence &amp; sentenced &gt;6 months</td>
</tr>
<tr>
<td>➣ Subject to national disqualification</td>
<td>➣ Cannot demonstrate has performed services during preceding 12 months</td>
</tr>
<tr>
<td>➣ Performer has died</td>
<td>➣ Prejudice to the efficiency of the service</td>
</tr>
<tr>
<td>➣ Performer is no longer registered with the relevant body</td>
<td>➣ Fraud</td>
</tr>
<tr>
<td>➣ Performer has been suspended substantially by their regulator</td>
<td>➣ Performer is unsuitable</td>
</tr>
<tr>
<td>➣ Medical performer is no longer on GP Register, has had license to</td>
<td>➣ Failed to comply with any conditions imposed by NHS England or the FTT</td>
</tr>
<tr>
<td>practise withdrawn or has breached an undertaking under 26(3)</td>
<td></td>
</tr>
<tr>
<td>➣ Dental performer has failed to complete foundation training</td>
<td></td>
</tr>
</tbody>
</table>

There is no right of appeal for mandatory removals and performers can be removed with immediate notice. These cases should be taken to the PLDP for ratification but do not require the notice period or performer representations.

6.14 How do you draft conditions?

The purpose of conditions is to mitigate any prejudice to the efficiency of the service or prevent fraud. In other words, conditions should safeguard any risk to patients and/or public finances by placing restrictions and/or obligations on the performer, enabling them to carry on practicing.
Performers must be able to demonstrate compliance with the conditions and failure to do so may result in removal from the performers list. The wording of conditions is therefore essential to ensure that they meet the objectives of safeguarding patients/public finances and are not open to misinterpretation.

Questions to Consider When Drafting Conditions

- What deficiency/concern are you trying to address?
- Do the conditions meet the objective?
- Are the conditions specific enough so that all parties understand what is expected?
- How will the performer demonstrate compliance/improvement?
- Are the timescales clear both for implementing and reporting?
- Do the conditions enable the performer to retain responsibility?
- Are the conditions achievable?

The performer is responsible for complying with the conditions and therefore there should be no onus placed on a third party, for example the deanery, as this would not be fair to the performer. The regulatory bodies have banks of conditions that NHS England may find useful to refer to.

INCORRECT

You will attend a training course on medical record keeping within 3 months

CORRECT

You must work with a supervisor appointed by your responsible officer to formulate a Personal Development Plan specifically designed to address the deficiencies in the following areas:
• Medical record keeping

Figure 11 provides two examples of a condition drafted to address concerns with medical record keeping. The first example does not adequately address the concern. The performer may be unable to find a record keeping course within 3 months resulting in him being unable to comply with the condition through no fault of his own. The performer may find a training course, which may not address the concerns and/or may then attend but learn nothing. In this latter example he will have complied with the condition but not addressed the deficiencies in his practice.
The second example enables the Responsible Officer to retain control by appointing an appropriate supervisor and using a personal development plan to address the deficiencies. The performer will then have to submit the personal development plan and evidence of progress to show compliance. Additional conditions can be used to specify reporting arrangements and any further evidence required.

**Key Issue/Point of Note**

The role of mentor and supervisor are very different. A supervisor provides a monitoring and reporting role for the performer and NHS England whereas a mentor supports the performer and discussions remain confidential between the two parties. It may be appropriate to appoint both but make sure that you specify reporting arrangements and timescales. For the post of mentor, you should ask for confirmation that the two parties are meeting but not the contents of the meetings.

Conditions should include timescales but not be time limited as the PL Regulations provide for review processes as discussed in more detail in section 6.17.

**6.15 What do you need to include in the decision letter?**

Except for immediate suspensions, the decision letter must be provided within 7 days and must include:

- The decision
- The reasons for the decision
- What evidence and facts relied upon and why
- Any right of review and appeal

Template letter have been provided including relevant references to the PL Regulations. In addition to these references, the decision letter should be sufficiently detailed to explain to the performer how and why the PLDP have arrived at their decision. In practice it is often drafted by a member of the Medical Team within NHS England, however it should be checked and authorised by the PLDP Chair. The Chair should be satisfied that the letter accurately reflects the PLDP’s deliberations and is consistent with any records made of the PLDP.
6.16 Who should be notified of the decision and when?

The PL Regulations require NHS England to communicate decisions made under the Regulations to a number of specified bodies within 7 days of the decision. The purpose of these notifications is to ensure that in the event that the performer is working elsewhere or decides to work elsewhere, other relevant bodies will be aware of the restrictions. From 1\textsuperscript{st} January 2015, notifications should also be sent to the Care Quality Commission.

Although the PL Regulations specify the notifications from a statutory perspective, there may be other parties who should be informed as a matter of good practice. This may include the Clinical Commissioning Groups or the Out of Hours Service.

6.17 What is the process for reviewing decisions under PL regulations?

Where NHS England has imposed conditions or a period of suspension there are requirements for when the decisions should be reviewed and when the performer can request them. Figure 12 shows when NHS England can review the decisions, when the performer can request a review and what the decision options are for a review. NHS England should follow the same process for notification as for other decisions, i.e.

\begin{footnotesize}
\textsuperscript{10} Regulation 18(2)
\end{footnotesize}
providing notice of what action is being considered and that the performer has the opportunity to provide written and/or oral representations.

**Suspension**
(under Reg 12(1)(a) or (b))

**Review when?**
- By NHS England at any time
- By the performer, after 3 months
- Once reviewed, not for another 6 months

**Decision Options**
- Maintain or vary suspension
- Impose conditions
- Remove the performer

**Conditions**
(under Reg 10, 11 or 12)

**Review when?**
- By NHS England at any time
- By the performer, after 3 months
- Once reviewed, performer cannot request for another 6 months

**Decision Options**
- Maintain or vary the conditions (including revoke them)
- Impose different conditions
- Remove the performer

Figure 12 Reviewing Decisions

When reviewing a decision, the PLDP should follow the same principles as when the initial decision was made in that they should be objective and act appropriately, proportionately and in the interests of patient safety. However, there is some merit in using the same PLDP members as the original decision makers. The reason for this is that these reviews do not require the PLDP to re-hear the evidence or to either question or validate the previous decision. Instead, the purpose of these reviews is to establish progress made by the performer in relation to conditions, and for suspensions to hear how any changes in circumstances have affected patient safety.

The performer should be notified of who the PLDP members will be, to enable them to raise any concerns about conflicts of interest. The PLDP Chair should also invite declarations of interest at the beginning of the meeting so that the process remains fair, open and transparent.

**6.18 What happens at an appeal hearing?**

The performer has a right of appeal where NHS England has refused their inclusion to the list, imposed, maintained or varied conditions or removed them from the list. Appeals are considered by the First Tier Tribunal Service who will undertake a complete
re-hearing of the case. The Tribunal can make any decision that NHS England can under the PL Regulations.

Both parties will be invited to make representations and the Tribunal will either consider the case based upon the paper evidence or will hold an oral hearing. It is possible that at this stage additional evidence may be available, which may lead to a different decision.

6.19 When do you involve an external body?

There are a number of external bodies that may need to be involved depending upon the circumstances.

6.19.1 NCAS

NCAS can be involved at any stage in the process for advice on how the case should be managed. The RO Regulations require the Responsible Officer to pay due regard to NCAS guidance but the NCAS Advisor also provides a useful sounding board for managing performance concerns. The advice is summarised in writing, which can be shared with the performer and the PAG and although you are not obliged to follow their advice, you should be able to justify why not if that is the case.

NCAS advice must be sought when NHS England is considering Performers List action.

NCAS also provide an assessment service where the underlying cause or extent of the performance concerns is unclear. The assessment process covers a number of areas including behaviour, health and performance. It is important to note though that a performer cannot be assessed if they are not well enough or they are not currently practising.

6.19.2 NHS Protect/Local Counter Fraud

Where the concerns relate to potential fraud, whether within the criminal definition or that specified in the PL Regulations, you should consult with NHS Protect. Your finance team will have the contact details for your local NHS Protect representative who will be able to keep you informed about the progress of the investigation. It is important to remember that the criteria applied by NHS Protect as to whether to progress an investigation and/or take action is very different from that applied by NHS England under the PL Regulations. Therefore, if NHS Protect decide not to pursue a case it does not necessarily mean that the Team should not consider whether action is appropriate under the PL Regulations. The concerns may not fall within the definition of fraud under PL Regulation 14(3)(c) but may still come under the grounds for efficiency and/or suitability. For more information on grounds for action see section 6.3.
6.19.3 Police

There may be cases where the police notify you of the concern or where during your own enquiries it becomes apparent that the police need to be involved. These cases may include allegations of fraudulent prescribing, falsifying death certificates, theft of drugs or assault. Whether the police have instigated the investigation or you have reported the concerns to them, the best way forward is to work in partnership with the police. One way to achieve this is to find out who your local liaison officer is. The Team should engage with the police and agree a joint strategy for the investigation including information sharing. It is important not to jeopardise the police investigation or contaminate any evidence, however if all parties are clear on their responsibilities, a joint approach can be the best way to manage the concern in a robust and timely manner.

**Case Example**

During a review of patient records, the investigator reports discrepancies in the information recorded on death certificates compared with the patient records. The dates on the certificates do not correspond with the date the patient was last seen as recorded on the patient record. The cause of death is frequently recorded as ‘old age’. You speak to the Coroner and agree that the police need to be informed. A meeting is arranged between the Medical Team and the police to agree a strategy. Regular meetings are held to share evidence gathered and to support the police in their enquiries. The Team are able to continue with their investigation in the meantime alongside the police.

6.19.4 Regulatory body

The professional regulatory bodies have distinct roles and responsibilities over their profession and, in this context, are concerned with fitness to practise. They have a statutory responsibility to safeguard patients, maintain public confidence in the profession and uphold professional standards. Whilst NHS England has similar statutory responsibilities, the test to be applied is fitness for purpose as opposed to fitness to practise; the question is whether the performer can provide primary care services as opposed to whether they should remain on their professional register.

Clearly these two thresholds may overlap and necessitate a referral to the regulatory body. This may occur where the risk to patient safety or the potential to undermine public confidence in the profession is significant. However, in most cases local resolution should be pursued first and only if this fails should the regulator be involved.

Anyone can refer a case to the regulatory body, although this is not a decision to be taken lightly. The PAG can make the decision to refer, although it is advisable to liaise
with the Responsible Officer/Medical Director. Ordinarily, it is a decision that should be made by the PLDP, as in most cases local resolution/management should be attempted first. When the decision has been made to refer the case to a regulatory body, a referral will need to be made along with the provision of supporting evidence/documents. The regulatory bodies review the evidence provided to them and go through a screening process to consider whether the risk to patients and/or the public interest is significant enough that interim action may be required and/or whether the evidence supports a fitness to practise concern.

The regulatory bodies do not usually undertake detailed investigations and are therefore heavily reliant on the findings of NHS England’s investigations. They collate information, obtain witness statements and instruct performance or health assessment but they do not investigate as NHS England does. It is very important therefore to ensure that when you make a referral, you are providing the regulatory body with detailed evidence/information obtained during your own investigations. It may be useful to provide an executive summary of the case and supporting evidence to assist with this process. The regulatory body may refer back to you for clarification or further information to progress their case. It can take a long time for them to go through their fitness to practise processes and during this time it is essential that NHS England continue with their own processes.

6.19.5 Care Quality Commission (CQC)

CQC have specific responsibilities in relation to service providers within health and social care. Many concerns are not specific to an individual performer – it may be that practice systems and/or culture have contributed to the performance concern. A performer in difficulty working in a supportive environment is less likely to require intervention and can usually be managed through local resolution or internally within their own practice perhaps with the support of their Local Representative Committee. However, where the performer is either the registered manager for the provider and/or there are concerns about the quality of services being provided that have arisen out of the performer concern, the CQC should be notified. The CQC may also notify NHS England of a concern arising from an inspection or other source.

The CQC may decide to undertake an inspection, regardless of whether they have visited the provider previously. You should liaise with the CQC Inspector and share information about your findings, which will support both parties’ enquiries and ensure triangulation of concerns. This is an important part of the process as patient safety concerns may manifest in different ways and may continue to present themselves as a case progresses.
Appendix A Template for Considering Concerns

The template includes some examples to illustrate the level of detail for the PAG to consider. This will be dependent upon the nature of the concern, however it should be enough information for the PAG to decide whether further enquiries or action should be taken. The PAG can always require further information/documentation if necessary.

<table>
<thead>
<tr>
<th>Date received</th>
<th>Case Number</th>
<th>Name of practitioner</th>
<th>Brief description of the issues / concerns</th>
<th>Recommendation for PAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/12/2014</td>
<td>GP673</td>
<td>Dr Phillipa Williams</td>
<td>Complaint received from a relative about Dr Williams’ failing to diagnose a scaphoid fracture. Patient had attended on two separate occasions with a painful wrist and was not referred for an x-ray. Clinical Advisor reports that the fracture was missed and that Dr Williams should have referred the patient for an x-ray earlier.</td>
<td>Dr Williams has acknowledged the incident and will provide a Significant Event Analysis to the NHS England Team by 30th January. This will be brought back to the next PAG meeting for consideration.</td>
</tr>
<tr>
<td>14/12/2014</td>
<td>D369</td>
<td>Dr Patryk Senkowski</td>
<td>Patient complaint received about the quality of fillings provided by Dr Senkowski. The patient reported that his fillings fell out shortly after treatment and Dr Senkowski refused to replace them unless the patient paid again. Dental Advisor has identified that this is the third complaint received about Dr Senkowski’s practice.</td>
<td>As this is the third complaint received, the PAG should make further enquiries and consider whether a review of Dr Senkowski’s practice is required.</td>
</tr>
</tbody>
</table>
Appendix B:1 Template for PAG Submissions

Introduction
How was the concern received, where from and what has been done to review or investigate it to date

Background
Include contextual information such as structure of the practice, patient list size and demographics, type of contract and systems in use

Summary of Issues Identified
Summarise concerns/issues received to date and status (i.e. investigated/not in dispute/still to be reviewed etc). Consider a timeline, in suitable cases.

Risk Assessment
Refer to the NHS England Risk Matrix to assess the risk of the case on the basis of the information available to the Area Team at this stage.

Framework and Regulatory Reference
Include appropriate references to the Framework for Managing Performance Concerns, PL Regulations or regulatory body guidance

Options for the Performance Advisory Group
There are a number of options open to the PAG under the Terms of Reference, which may be appropriate in this case.

Therefore, given the nature of the concerns and the previous history, the PAG should consider the following options:

• .....
Appendix B:2 Template for PLDP Submissions

Introduction
How was the concern received, where from and when was the investigation instructed. Was the PAG involved?

Background
Include contextual information such as structure of the practice, patient list size, demographics, type of contract and any relevant factors to the case

Summary of Findings
List the findings of the investigation in relation to the allegations and cross-reference to supporting papers. Consider a timeline, in suitable cases.

Framework and Regulatory Reference
Include appropriate references to the Framework for Managing performance Concerns, PL Regulations or regulatory body guidance

Recommendations/Options
Include the options available to the PLDP taking into account the PL Regulations, the Terms of Reference for the PLDP, and the grounds and action being considered where the notice letter has been issued to the performer
**Appendix C Decision Tree**

**Deliberate Harm**
- Were the actions as intended?  
  - Yes
  - No
  - Yes: Consult NCAS and relevant regulatory body. Advise performer to consult with their defence organisation. Consider: Immediate, Suspension, Referral to Police
  - No: Were the consequences intended?
    - Yes
    - No
    - Yes: Consult NCAS. Consider: Sick leave, Referral to Occupational Health, Reasonable adjustment to duties
    - No: Does the individual have a known medical condition?
      - Yes
      - No
      - Yes: Did the performer depart from agreed standards / guidelines?
        - Yes
        - No: Were the standards / guidelines in routine use?
          - Yes
          - No: Were there any deficiencies in training or experience?
            - Yes
            - No: Were there significant mitigating circumstances?
              - Yes
              - No: Consult NCAS or relevant regulatory body. Advise performer to contact defence organisation. Consider: Referral to disciplinary / regulatory body, Referral to Occupational Health, Reasonable adjustment to duties, Suspension
              - No: This may be indicative of a system failure. Review System
      - No: Does there appear to be evidence of ill health or substance abuse?
        - Yes
        - No
        - Yes: Is there evidence that the individual took an unacceptable risk?
          - Yes
          - No: Consult NCAS. Consider: Remediation, Occupational Health referral, Reasonable adjustment to duties, Supervision / mentorship
          - No: Did the performer depart from agreed standards / guidelines?
            - Yes
            - No: Were the standards / guidelines in routine use?
              - Yes
              - No: Were there any deficiencies in training or experience?
                - Yes
                - No: Were there significant mitigating circumstances?
                  - Yes
                  - No: Consult NCAS or relevant regulatory body. Advise performer to contact defence organisation. Consider: Referral to disciplinary / regulatory body, Referral to Occupational Health, Reasonable adjustment to duties, Suspension
                  - No: This may be indicative of a system failure. Review System
    - No: Consult NCAS and relevant regulatory body. Advise performer to consult with their defence organisation. Consider: Immediate, Suspension, Referral to Police
Appendix D Suspension Flowchart

1. **Serious patient safety / misconduct concern received**

2. **Concern considered by Medical Director + one other Director**

3. **Is suspension necessary for the protection of patients, members of the public or is otherwise in the public interest?**

4. **Is an immediate suspension necessary?**
   - **Yes**
     - **Immediate suspension imposed**
     - **Notify practitioner immediately**
   - **No**
     - **Two PLDP members (not involved in the 1st decision) review the decision to suspend the following working day**

5. **Suspension revoked and practitioner notified**

6. **Decision to suspend maintained and practitioner notified**

7. **Notice sent to practitioner including**
   - What further action is being considered
   - Grounds relied upon
   - At least 2 working days notice of opportunity to present case at oral hearing

8. **PLDP (members not previously involved in the decision making so far) consider case & any representations made**

9. **Allow practitioner to resume practice with conditions**
   - NB. This option only available where the practitioner has requested & attended an oral hearing

10. **Revoke the suspension & enable practitioner to resume practice**

11. **Confirm decision to suspend**
## Appendix E Procedure for Oral Hearing

### Opening the Oral Hearing

- The Chair welcomes all parties and invites introductions
- The Chair asks PLDP members if there are any declarations of interest. If any are declared, parties are invited to comment and the PLDP will consider whether any action, such as adjournment, is required
- The Chair explains the process and rules for the hearing
- The Chair asks parties to clarify any matters in dispute

### NHS England’s Case

- NHS England presents their case taking the PLDP through the evidence referring to the allegations
- The performer/representative may ask questions of NHS England
- The PLDP members may ask questions
- If witnesses are called (NB. witnesses must be approved beforehand by the Chair):
  - NHS England introduces the witness and asks relevant questions
  - The performer/representative may ask questions of the witness
  - The PLDP members may ask questions of the witness

### Performer Representations

- The Chair invites the performer to make their representations
- The performer/representative responds to NHS England’s case referring to relevant evidence
- If witnesses are called, the same process is followed as previously
- NHS England may ask questions
- PLDP members may ask questions
NHS England’s Proposed Action

- The Chair invites NHS England to confirm the proposed action that the PLDP are being asked to consider
- NHS England states the action to be considered and on what grounds, clarifying any matters arising from the evidence
- The Chair invites the performer/representative to respond to the proposed action

PLDP Deliberations

- The Chair asks NHS England and the performer/representative to leave whilst the PLDP consider the case
- The PLDP consider the evidence and representations in private referring to the relevant factors under the PL Regulations
- The PLDP make their decision clearly identifying the facts relied upon and the reasons for their decision

PLDP Decision

- If the performer has stayed for the decision, the Chair invites the parties back in
- The PLDP Chair confirms the decision and brief reasons for the decision and explains that it will be confirmed in writing within 7 days of the hearing
Appendix F – PAG/PLDP Process Overview

1. PAG receive concern & assess
2. PAG instruct investigation
3. Investigation report received raising concerns. PAG decide to refer to PLDP for action under PLR
4. Case considered at next scheduled PLDP. PLDP identify action to be considered & grounds
5. Notice letter & evidence bundle sent to performer identifying grounds and action to be considered
6. Has performer requested an oral hearing?
   - Yes: Oral hearing scheduled as soon as possible
   - No: Case considered at next scheduled PLDP
7. PLDP members need to be independent from the previous Panel considering action & grounds
Appendix G Equality

Equality Duties

The Protected Characteristics

1.1 The Equality Act 2010 prohibits unlawful discrimination in the provision of services (including healthcare services) on the basis of “protected characteristics”. The protected characteristics are:

1.1.1 age
1.1.2 disability
1.1.3 gender reassignment
1.1.4 marriage and civil partnership
1.1.5 pregnancy and maternity
1.1.6 race
1.1.7 religion or belief (which can include an absence of belief)
1.1.8 sex
1.1.9 sexual orientation

Unlawful discrimination can also occur if a person is put at a disadvantage because of a combination of these factors.

Unlawful Discrimination

1.2 There are broadly four types of discrimination in the provision of services that are unlawful under the Equality Act:

1.2.1 Direct discrimination services are not available to someone because they are e.g. not married, over 35, a woman. Apart from a few limited exceptions, direct discrimination will always be unlawful, unless it is on the grounds of age and the discrimination is a proportionate means of achieving a legitimate aim.

1.2.2 Indirect discrimination occurs when NHS England apply a policy, criterion or practice equally to everybody but which has a disproportionate negative impact on one of the groups of people sharing a protected characteristic, and where the complainant cannot themselves comply. The classic example is a height requirement, which is likely to exclude a much greater proportion of women than men because women are on average significantly shorter. Requirements that require people to behave in a certain way will amount to indirect discrimination if compliance is not
consistent with reasonable expectations of behaviour. For example, a requirement not to wear a head covering would be indirectly discriminatory on the grounds of religion, even though followers of religions which require a head covering are physically able to remove it.) Indirect discrimination is not unlawful if it is a proportionate means of achieving a legitimate aim.

1.2.3 Disability discrimination occurs if a person is treated unfavourably because of something "arising in consequence of their disability". This captures discrimination that occurs not because of a person’s disability per se (e.g. a person has multiple sclerosis) but because of the behaviour caused by the disability (e.g. use of a wheelchair). So an inability of someone with multiple sclerosis to access services when using their wheelchair could be an instance of disability discrimination. Disability discrimination is not unlawful if it is a proportionate means of achieving a legitimate end.

1.2.4 A failure to make "reasonable adjustments" for people with disabilities who are put at a substantial disadvantage by a practice or physical feature. The duty also requires bodies to put an "auxiliary aid" in place where this would remove a substantial disadvantage e.g. a hearing aid induction loop. The duty to make reasonable adjustments might e.g. require NHS England to make consultation materials available in braille. However some care is needed here. People with disabilities have a right to access services in broadly the same way as people without disabilities, so far as is reasonable. Offering a telephone consultation to a wheelchair using patient who is prevented from accessing a clinic by steps may in fact be unlawful discrimination rather than a reasonable adjustment. The wheelchair user should be able to access services in broadly the same way as others i.e. by attending practice premises for a consultation.

(Unlawful discrimination is also prohibited in the field of employment and other areas but these are not covered in this guidance.)

Public Sector Equality Duty

1.3 As well as these prohibitions against unlawful discrimination the Equality Act 2010 requires NHS England to have "due regard" to the need to:

1.3.1 eliminate discrimination that is unlawful under the Act;

1.3.2 advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; and

1.3.3 foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
This can require NHS England to take positive steps to reduce inequalities. In this regard the Act permits treating some people more favourably than others but not if this amounts to unlawful discrimination. The duty is known as the public sector equality duty or PSED (see section 149 of the Act). The PSED has been used successfully on many occasions to challenge changes to services.