East of England Ambulance Service NHS Trust

Variations in Clinical Practice & Clinical Competency Policy

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DOCUMENT CHANGE HISTORY		
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Quality & Governance Committee	July 2010, with extensions 2013-2015	Clinical General Manager, Medical Directorate
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Equality Analysis	Completed
Linked procedural documents	Scope of Practice Policy Clinical Supervision Policy Managing Conduct and Performance Policy Trust's Disciplinary Policy (Managing Conduct and Performance)
Dissemination requirements	Trust wide
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior

managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

Contents

Appendices

1. Introduction

EEAST is an out-of-hospital and community care ambulance provider which services patients with a diverse range of routine, urgent, unscheduled and emergency care needs. It can be a challenging and dynamic environment in which to deliver clinical care. Every call will have different circumstances and presentations and we recognise that applying a pre-determined approach to clinical care for every presentation can be difficult. This policy underpins a supportive framework when a variation of clinical practice from standard policy or process occurs or an individual's clinical competency is questioned. This policy will support and appraise all staff, volunteers and learners undertaking clinical care on behalf of EEAST, where a variation of practice occurs or clinical competency event requires a review.

2. Purpose

This document outlines the Variations in Clinical Practice and Clinical Competency Policy for EEAST. The objectives are:

- To establish a clear pathway for dealing with issues of adequacy of performance and competency of clinical staff, and any variations relating to clinical practice.
- To establish a clear separation between these issues and those that pertain to matters of personal misconduct and capability.
- To encourage staff, volunteers and learners to openly discuss patient care issues in a supportive environment without the threat of blame.
- To offer a fair and balanced appraisal of any occurrence that may be considered adverse, including preventing recurrence of adverse incident.

3. Duties

3.1 Chief Executive

The Chief Executive has overall accountability for the quality of clinical care delivered at EEAST. They are responsible for having an effective risk management system in place within the Trust and for meeting all statutory requirements and adhering to guidance issued from the Department of Health, governing and assessment bodies.

3.2 Deputy Clinical Director / Consultant Paramedic

The Deputy Clinical Director – Clinical Effectiveness is responsible for the Variations in Clinical Practice and Clinical Competency Policy. They will ensure there is clinical leadership and systems embedded within the operational sectors to ensure evaluation of compliance. They are responsible for final appeals of outcomes from any stage II review process related to non-learners.

3.3 Head of Clinical Education

Is responsible for the clinical variation and clinical competency of all learners at EEAST. They are responsible for appeals of outcomes from any stage II final appeals related to learners.

3.4 Deputy Head of Clinical Education

Will support stage I appeals related to the clinical variation and clinical competency of all learners at EEAST.

3.5 Leading Operations Manager (Training & Education Portfolio) or other local officer leading on clinical practice.

Is responsible for the compliance of approach to clinical scope of practice. They will appraise any variation in clinical practice with the staff member, volunteer or learner as part of a stage I approach.

3.6 Clinical Practice Specialists

Will jointly appraise variation in clinical practice and competency with the local Leading Operations Manager (training and education portfolio) or other local officer leading on clinical practice as part of stage I reviews, if this pertains to learners.

3.7 Clinical Supervisor

Will undertake the clinical supervision of the clinical workforce. They will appraise on a periodic process of staff compliance to EEAST policy, JRCALC and other national best practice guidance during their observations shifts. They will highlight where there may be an issue with clinical competency.

3.8 Clinical Leads

There will be a Sector Clinical Lead per sector. They will undertake stage II reviews or undertake an appeal against the decision of stage I reviews.

3.9 Regional Support Teams

Leads within the wider EEAST regional teams can provide subject matter expertise in the areas of

- Infection Prevention & Control
- Patient Safety
- Violence Prevention & Reduction
- Risk
- Safeguarding
- Clinical Quality
- Audit & Research

4. Definitions

Term	Definition
Clinical Debrief	A relaxed / informal verbal conversation between a member of staff / crew and an EEAST clinical leader. This is recorded on a clinical debrief form and will form part of a stage I approach.
Interview	A formal process of dialogue between a member of staff / crew who has a clinical variation / clinical competency concern raised and an EEAST clinical leader and will form part of a stage II approach.
Investigation	Identifying the background details of a clinical variation / clinical competency concern to inform the decision whether this can be resolved locally via a stage I approach, or in a more serious case will need a stage II panel approach.

5. Poor Conduct Vs. Variation of Clinical Practice

The policy is not intended to prevent issues of staff, volunteer or learner conduct and performance being dealt with by other appropriate EEAST policies.

Whilst no disciplinary sanctions are to be considered as part of this policy, there may be occasions whereby during the investigation, interviews or clinical debrief, that issues come to light where it is deemed appropriate to invoke the Trust's Disciplinary Policy (Managing Conduct and Performance) rather than continue with this process.

Poor conduct	• Behaviours not aligned to EEAST values. • Wilful and recurring non-compliance with EEAST

	policy, guidance and instruction. • Recurring competency falling below the benchmarked level (see scope of practice policy). • Compromised of conduct, performance, ethics, or integrity (see professional standards section in the scope of practice policy).
Variation of clinical practice	• Isolated occurrence • Justifiable explanations • Situational dependent

6. Fitness to Practice Referrals

6.1 This policy will allow the Trust to manage clinical performance issues without always having the need to refer to professional/registration bodies. However, there may be cases, for example, where fitness to practice is deemed compromised and a referral decision needs to be made to protect both the individual and the public.

6.2 This decision would be made at Deputy Clinical Director (DCD) level or above on behalf of EEAST.

7. Procedure

7.1 This procedure is divided into two approaches:

Stage I: Local Resolution

Stage II: Clinical Performance Panel.

Prior to initialisation of a stage I or II process, consideration should be made if this is an isolated occurrence vs repetitive or recurring competence issues. For repetitive or recurring competence issues, this is not the appropriate policy to be managing the staff, learner or volunteer through.

7.2 Upon assessment of the initial information provided, consideration should be given as to whether suspension or other form of clinical or operational restrictions may be required. Authority to suspend should follow the same process as set out within the Trust's Disciplinary Policy (Managing Conduct and Performance).

7.3 Where clinical or operational restrictions to practice are to be instigated this will need to be authorised by a substantive Band 8c manager or above. Where this relates to a learner, this should be done in liaison with a senior leader in the Education & Training Team.

7.4 Having collected all the evidence, the investigating manager should conduct a clinical review of the facts. This clinical review should seek to ascertain whether the incident can be dealt with at Stage I (Local Resolution) or whether there is a need to invoke Stage II (Clinical Performance Panel) and documented accordingly.

The member of staff should be aware they are being managed under the clinical variations and competency policy, and at what stage.

7.5 When reviewing the facts, the investigating manager is encouraged to seek expert clinical guidance from the clinical directorate for clinical matters, or the education and training team for learners.

7.6 It is felt that any issue that will require EEAST to report to the relevant regulatory body as part of a fitness to practice consideration should move to a stage II panel review. The recommendation should be made to the DCD or equivalent, as per section 6.2.

8. Stage I – Local Resolution & Debrief

8.1 Having decided to seek a local resolution via a clinical debrief, the manager conducting it should consider incorporating additional expert assistance within the debrief if it is deemed necessary.

8.2 The Clinical Debrief should be conducted in an informal and relaxed atmosphere with the emphasis placed on learning lessons and improving clinical practice. Emphasis must be placed on confidentiality of the issues discussed.

8.3 Individuals must be advised that they can be accompanied by a Trade Union representative or fellow worker (i.e., another of EEEAST workers).

8.4 If as a result of the clinical debrief it is decided that no further action is required this must be documented on the clinical debrief form (Appendix A) which should be dated, signed by and copied to all relevant parties involved in the debrief.

8.5 If needed, an action plan should be agreed with the individual at the end of the debrief, and recorded in writing on the clinical debrief form which should be dated, signed by and copied to all relevant parties involved in the debrief.

<u>An action plan may include:</u>

- A period of mentoring (length of time to be mutually agreed);
- Time with the mentoring, support and training team vehicle (MSTT)
- Additional training and education;
- Formal assessment, (simulation or 'live');
- Reviewing or recommending changes to equipment, guidelines or practice;
- Case study submission which is relevant to the incident(s) or area of poor practice/competence (including marking guidance);
- Changes to working practices.

If necessary, a review date will be agreed in order to assess progress and this should involve those present at the debrief. It may not be necessary to convene another meeting to review progress as this often can be done using other communication links.

8.6 A summary of the debrief should be forwarded to the Sector Clinical Lead and the local General Manager for that area. This summary should be recorded on a Clinical Debrief Form.

Anonymised summaries of clinical debriefs will be discussed at local clinical review groups.

8.7 If at any point during Stage I it is considered more appropriate to deal with the matter under either Stage II (Clinical Performance Panel) or the Trust's Disciplinary Policy (Managing Performance and Conduct) the Stage I process will stop. The employee will be informed in writing of the reason why and the more appropriate pathway to be followed.

8.8 If the manager conducting the Stage I clinical debrief feels it more appropriate to move the matter to either Stage II or the Trust's Disciplinary Policy then the relevant section of the clinical debrief form (QA3) should be completed outlining the reasons for their decision and forwarded to the Sector Clinical Lead and General Manger for that area.

8.9 Should there be an inconclusive outcome following the debrief, then the matter should move forward to Stage II.

9. Stage II – Clinical Performance Panel

9.1 For more serious clinical issues where the matter has been progressed from Stage I, or multiple complaints, or those that cannot be resolved at stage I, then Stage II will be invoked and a Clinical Performance Panel will be convened.

9.2 This should occur within 28 calendar days of the investigating manager's clinical review of the facts or the date of the Stage I outcome. All paperwork should be shared immediately after the decision has been taken to progress to Stage II. If the timescale cannot be adhered to due to legitimate reasons then the nominated chairperson should document the reasons and reassign another date which is agreeable to all parties.

9.3 The panel will be organised by the HR Department in conjunction with the Chair, and will comprise of the following:

- A Chairperson who would normally be the Sector Clinical Lead, or other senior manager from the medical directorate.

- An appropriate manager from the domain the individual is employed in or in the case of a learner, the Higher Education and Clinical Practice Lead or other senior education manager.
- A staff representative nominated by UNISON who should have extensive clinical experience and credibility and is a staff peer whose skills level is representative of the employee attending the clinical review panel.

9.4 In special circumstances, the panel may invite an independent or an expert view, if this will help to improve the quality of the conclusion or decision of the panel.

9.5 Whilst the initial investigating manager should not be invited to sit on the panel, they may be required to attend the panel hearing for clarity.

9.6 The member of staff will be invited to attend and be advised that they can be accompanied by a Trade Union representative or fellow worker (i.e., another EEAST's worker). The format of the stage II process is designed to be fair and supportive and is not a disciplinary process.

9.7 The panel members will have a meeting prior to the commencement of the panel hearing to discuss the case and formulate questions and an agenda of proceedings.

9.8 If as a result of the panel's findings it is deemed that the issue is better dealt with under the Trust's Disciplinary Policy (Managing Conduct and Performance) the Chairperson will complete the relevant section of the Clinical Debrief Form (Appendix A) outlining the reasons for their decision and copy it to the Human Resources Department, who will then make arrangements for a disciplinary hearing to be convened. In these circumstances the individual must be informed of this decision either prior to, during or at the end of the meeting.

9.9 The panel should consider what the current clinical standards of the individual are along with any current or previous issues. If a deficit in clinical performance is identified, the panel must formulate a plan of action. This may include:

- Additional training, mentorship or personal learning plan;
- Reviewing or recommending changes to equipment, guidelines or practice;
- A programme of reviewing performance to ensure that high standards of clinical practice are maintained;
- Changes to working practices;
- Take no further action

9.10 If the panel is reviewing a doctor then a report from the panel should be sent to the clinical commissioning group on whose provider list the doctor is registered.

9.11 Upon reaching their decision, the panel chair must communicate this to the individual. This should be done at the end of the panel hearing with written confirmation within eight calendar days.

9.12 If required, the panel will set a review date in line with their recommendations which should normally be within six months of the hearing date.

9.13 The panel Chair will confidentially report its conclusions to the Trust's Deputy Clinical Director (Clinical Effectiveness), with a copy forwarded to the Human Resources Department for the employee's personnel file.

9.14 The HR department will keep a complete copy of all the documentation used by the Panel.

9.15 The Deputy Clinical Director (Clinical Effectiveness) is responsible for the preparation of an anonymised report biannually to the Risk & Compliance Committee summarising the incidents considered, and will undertake an annual review of the functionality of the panel composition in partnership with staff side.

10. Appeals Procedure & Policy Review

10.1 The individual may appeal against the outcome of the Clinical Performance Panel. The appeal must be sent in writing to the Medical Director within 14 calendar days of receipt of the written outcome of the meeting.

10.2 The appeal for a stage I approach will be a sector Clinical Lead and in the case of a learner, the Higher Education and Practice Lead. Alternatively, the hearing can be progressed to a stage II approach.

10.3 The appeal for a stage II hearing, this will be heard by a senior Trust management group comprising of the following:

- A Chairperson who would normally be a Deputy Clinical Director or senior from the medical directorate.
- The Clinical Lead for Education & Clinical Practice / Consultant Paramedic
- A senior Human Resources manager.

10.4 When lodging an appeal, the employee should state:

a) the grounds of their appeal;

b) whether they are appealing against the finding that they have committed the alleged act(s) of unacceptable variation of clinical practice, or against the plan of action.

10.5 At the conclusion of the proceedings the individual will be informed of the decision of the group hearing the appeal (If the individual is a doctor then their clinical commissioning group will be informed of the decision). In the event that a clinical outcome which had previously been reported is overturned at appeal, then the Chair of the appeal panel will write to the appropriate registration body.

10.5 There is no right of appeal against the decision to move from clinical review to the Disciplinary Policy (Managing Conduct and Performance).

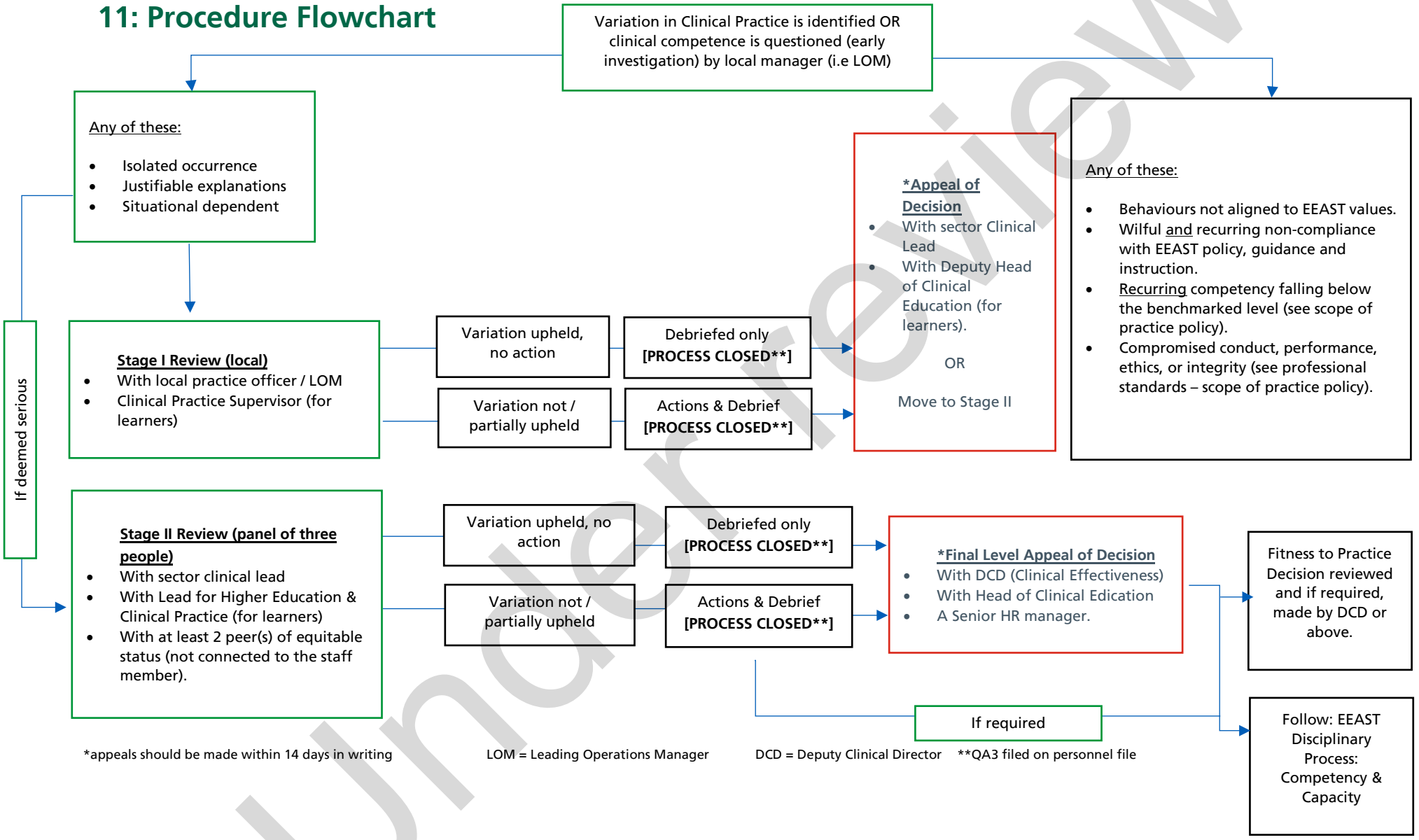
10.6 There is no further routes of appeal internally at EEAST.

10.7 This policy will be reviewed on a two-yearly basis or more frequently if significant changes to its effective operation are necessary

QA3: Clinical Debrief Form					
Persons Name:	Chair / Lead name:	Quality Assured: Yes/No, Name:			
Clinical Grade:	Locality / Department	Date	Start	Finish	
Stage I Review		Others Present at Review:			
Stage II Review					
Description of Events / Issues					
Debrief Findings					
Recommendations / Conclusion					
Lessons Learnt / Action Plan					

Crew Member 1:	**Signature:**
Crew Member 2:	**Signature:**
Chair of Review	**Signature:**
To be forwarded to HR to be added to personnel file To be forwarded to General Manager	

11: Procedure Flowchart



*appeals should be made within 14 days in writing

LOM = Leading Operations Manager

DCD = Deputy Clinical Director

**QA3 filed on personnel file

Appendix A - Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
				.	The lead or committee is expected to read and interrogate any report to identify deficiencies in the system and act upon them	Required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Documentation of events via QA3 forms	Local manager undertaking	When an occurrence has been	As required	QA3 forms	Trust-wide Professional Standards Committee	The DCD (Clinical Effectiveness) will review SoP policy /	New programmes

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
	Stage I review	raised for evaluation				approach if required.	

Appendix B - Equality Impact Assessment

<table>
<tr><th colspan="2">EIA Cover Sheet</th></tr>
<tr><td>Name of process/policy</td><td>Variations in Clinical Practice & Clinical Competency Policy</td></tr>
<tr><td>Is the process new or existing? If existing, state policy reference number</td><td>V4</td></tr>
<tr><td>Person responsible for process/policy</td><td>Deputy Clinical Director (Clinical Effectiveness)</td></tr>
<tr><td>Directorate and department/section</td><td>Medical Directorate</td></tr>
<tr><td>Name of assessment lead or EIA assessment team members</td><td>A Kitchener</td></tr>
<tr><td>Has consultation taken place?

Was consultation internal or external? (please state below): internal</td><td>Yes</td></tr>
<tr><td>The assessment is being made on:</td><td>
<table>
<tr><td>Guidelines</td><td></td></tr>
<tr><td>Written policy involving staff and patients</td><td>x</td></tr>
<tr><td>Strategy</td><td></td></tr>
<tr><td>Changes in practice</td><td></td></tr>
<tr><td>Department changes</td><td></td></tr>
<tr><td>Project plan</td><td></td></tr>
<tr><td>Action plan</td><td></td></tr>
<tr><td colspan="2">Other (please state)

Training programme.</td></tr>
</table>
</td></tr>
</table>

Equality Analysis

What is the aim of the policy/procedure/practice/event?

To ensure quality of clinical practice through a systematic clinical assessment / supervision process.

Who does the policy/procedure/practice/event impact on?

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Who is responsible for monitoring the policy/procedure/practice/event?

The policy will be jointly monitored by the medical directorate and the HR team. Those involved in stage I and stage II reviews should ensure that policy is followed including schedules and response times, as defined in the policy.

What information is currently available on the impact of this policy/procedure/practice/event?

This is an existing policy, undertaking an update and reformatting. There is little change in the process / practice related to clinical variation and clinical competency.

Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? Yes/No

No

Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? Yes/No, If yes please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐

Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence:

The policy is applied across all clinical workforce irrespective of background.

Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? Yes/No, if so please provide evidence/examples:

Race	☐	**Religion/belief**	☐	**Marriage/Civil Partnership**	☐
Gender	☐	**Disability**	☐	**Sexual orientation**	☐
Age	☐	**Gender re-assignment**	☐	**Pregnancy/maternity**	☐

Please provide evidence: No identified concerns

Action Plan/Plans - SMART

Specific

Measurable

Achievable

Relevant

Time Limited

Evaluation Monitoring Plan/how will this be monitored?

Who: Clinical Lead for Education & Clinical Practice

How: Via thematic analysis, case variance and audit

By: Chair of the Professional Standards Group

Reported to: The policy will be monitored by the Professional Standards Group