NHS
National Clinical Assessment Service

Handling concerns about a practitioner's behaviour and conduct

An NCAS good practice guide

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1. Introduction

1.1 Background

The National Clinical Assessment Service (NCAS) was established in 2001. It advises healthcare managers where they have a performance management concern about the practice of a doctor, dentist or pharmacist. As part of its work NCAS has identified that a significant proportion of the concerns it sees (59%)[1] contain a behavioural or conduct component. Even where clinical concerns about an individual's practice are not present, behavioural and conduct issues can nevertheless have a significant and detrimental impact on team relationships and patient care. We therefore dedicated our 2011 Annual Conference to understanding and tackling behaviours that can give rise to conduct problems in the workplace. Recognising these types of concerns can be complex; behavioural concerns should be considered in the individual circumstances of the case. This guide distils some of the feedback and learning from the conference as well as our practical experience of over 10 years of supporting healthcare managers. It is a "lessons learned" document drawing on NCAS experiences from referrals.

1.2 What constitutes poor behaviour and conduct?

There is no standard definition of behavioural concerns in clinicians in the UK. The College of Physicians and Surgeons of Ontario, Canada and the Ontario Hospital Association have for a number of years been collecting evidence about issues of poorly behaving practitioners and about how difficult it can be to resolve behavioural concerns. Their 2008 guidance, *Guidebook for managing disruptive physician behaviour*,[2] defines behavioural concerns (here called disruptive behaviour) as follows:

> *Disruptive behaviour occurs when the use of inappropriate words, actions or inactions by a physician interferes with his or her ability to function well with others to the extent that the behaviour interferes with, or is likely to interfere with, quality health care delivery.*

Behavioural concerns can manifest themselves in practitioners who are otherwise clinically sound, often when there has been some change in their personal life or to their working environment. An analysis of 1472 cases handled by NCAS between December 2007 and March 2009 showed that work environment influences were a factor in 11% of cases. Issues included problems with team working, systems and support and resource issues.[3]

The guide refers to behaviour and conduct. It is important not to disregard poor behaviour even if the practitioner is clinically sound. Poor behaviour, which can include unpredictability, irritability, aggression, arrogance and hypersensitivity, can result in poor conduct including a failure to abide by organisational rules, poor team relationships and leadership, withdrawal or non-participation and a failure to comply with reasonable management requests. Behavioural issues can also put patient safety at risk.

1.3 How to use this guide

This guide is not a substitute for the provisions of local performance management procedures including Performers' List Regulations and Maintaining High Professional Standards in the Modern NHS (MHPS) and should be read alongside these procedures or existing frameworks for managing poor performance. Instead, this guide sets out principles and practical steps, which can be followed across all healthcare sectors and in any healthcare profession. It is written for primary care organisations (PCOs) and their successor bodies as well as organisations providing hospital and community (H&C) services, in both the NHS and independent sectors of healthcare.

This guide is not designed for use with trainees. Deanery procedures exist for dealing with practitioners in difficulty, although the approaches outlined here may still facilitate a resolution of the concern in an employment context. However, conduct matters that are not related directly to training (for example, persistent lateness) may be dealt with by the contracting or employing organisation's local procedures in liaison with the Deanery.

This guide can be used alongside other NCAS publications including *How to conduct a local performance investigation* and other good practice guides available from our website. The guide makes the assumption that advice and support will be sought from the local HR resource or the responsible organisational manager at all stages of the management process. In addition, contacting NCAS will provide access to our expert advisers - senior staff from a variety of backgrounds in the clinical, managerial and legal professions with considerable experience in handling concerns about professional practice. They will provide help about the handling of specific cases and the options for addressing the concerns: for example, in the form of a behavioural assessment and remediation (see our website for details about how to contact NCAS).

Different regulations, frameworks and guidance will apply across different professions and jurisdictions within the UK and so it is important to consult fully the applicable legislation and guidance. NCAS advisers can advise on this in specific cases.

1.4 Terms

Key NCAS terms used in this guide are:

Practitioners: doctors, dentists and pharmacists. These are professions within NCAS' current remit, although organisations may find this guide useful for other health professionals.

Concerns about practice: any aspects of a practitioner's performance or conduct, which may:

- pose a threat or potential threat to patient safety;
- expose healthcare services to financial or other substantial risk;
- undermine the reputation or efficiency of healthcare services in some significant way;
- be outside acceptable practice guidelines and standards.

Responsible manager: the person to whom a practitioner reports and who holds responsibility for handling the possible impact of the practitioner's behaviour on their clinical practice. This might be the Medical Director, Clinical Director or another manager. The responsible manager's prime concern is fitness for purpose of the individual – is the practitioner fit to meet the requirements of their job? In medicine, the responsible manager may also be the responsible officer. If this is not the case, there should be clear lines of communication between the responsible manager and the responsible officer.

Responsible officer: From 1 January 2011, a senior doctor who is appointed by a healthcare organisation to discharge responsibilities under the Medical Profession (Responsible Officers) Regulations 2010. Those responsibilities include ensuring that the organisation carries out regular appraisals of medical practitioners; establishing and implementing procedures to investigate concerns about a medical practitioner's fitness to practise; where appropriate, referring a medical practitioner to the GMC; and making recommendations to the GMC about a medical practitioner's fitness to practise. The responsible officer may also be the responsible manager, but the distinction between the two aspects of their role is important. There should be clear lines of communication between the responsible manager and responsible officer where these roles are undertaken by separate individuals within an organisation.

2. Categorising the concern

2.1 Recognising behavioural markers

Concerns about practice in relation to an individual's behaviour and conduct may present in different ways.

Although it may be easy to identify a practitioner who is consistently rude and aggressive towards colleagues, practitioners who are agreeable may also present behavioural difficulties for example by not being sufficiently assertive or by being over-cautious and reliant on help from others. In other circumstances, a practitioner's desire to do a job well and particularly to please their patients, may at times border on an overly fixed or rigid approach that means their behaviour can cause conflict and tension with others. This may include for example prescribing antibiotics that patients request against local and national guidance or doggedly rebooking follow-ups with medical staff when trust policy is for nurse follow-up or discharge back to primary care from hospital.

Recognising the behavioural markers and dealing with concerns early on may prevent escalation to a serious problem. It is important to determine what standard or organisational rule has been breached and whether the possible cause of this may relate to health as this informs the process to be followed.

2.2 Health and behaviour

It is not uncommon for behavioural problems to manifest because of an underlying health concern such as depression, anxiety, substance misuse, personality disorder or cognitive impairment, as well as some physical disorders. At referral, 9% of NCAS cases have both a behavioural and health component. Health concerns including disability can affect a practitioner's mood, concentration, energy and temperament. The feelings brought about by behavioural and conduct issues, before or when an individual becomes subject to performance management, can themselves lead to poor health

It is important early on to determine the extent to which a behavioural or conduct problem may result from health factors or may be a standalone issue. Appropriate health advice, including specialist mental health advice where required, should be sought first where an underlying health condition is suspected or known about. This advice should cover not only the status of any health problem but also advice concerning the prognosis and management of risk arising from possible future episodes in recurrent problems.

It is also incumbent on the practitioner to recognise where their health may be affecting their performance as part of their responsibilities under the GMC Guide to Good Medical Practice, GDC Standards for Dental Professionals and GPhC Standards of conduct, ethics and performance.

Depending on the findings, it may be that the primary concern is one of health. The practitioner should therefore be subject to health procedures in the first instance. The responsible manager should revert to conduct procedures only when all reasonable steps under health procedures have been exhausted. The NCAS good practice guide *Handling concerns about a practitioner's health: a guide for managers* provides further information about managing practitioners with health concerns (available from the NCAS website).

2.3 Other personal circumstances affecting behaviours

It is also important to explore, particularly where the behaviour appears out of character, whether there are any personal circumstances for which the individual may need appropriate support. A

preliminary conversation with the practitioner may clarify this and whether there are relevant and genuine contributory factors.

2.4. Formal action on conduct issues

Thinking about behaviour can assist in considering what may lie behind a concern and the approach that may shape remediation.[4] However, there is some distinction between conduct and behaviour in procedural terms. Where formal action is appropriate, irrespective of the cause or type of behaviours, the matter should be dealt with first according to local conduct procedures, either under Performers List Regulations, where those apply, or under Part III of Maintaining High Professional Standards or other appropriate local procedures.

Often there are multiple factors contributing to concerns about a case. It is important to assess what are the core strands to the concern as this informs which procedure to use.

In primary care, decisions need to be made about whether the concerns are sufficiently serious to trigger Performers List Regulations (2004 & 2010) action or in the case of contractor pharmacists, NHS (Pharmaceutical Services) Regulations 2005.

MHPS (Part III) makes the distinction between general conduct and conduct of a professional nature. Whilst the process is essentially the same in that local conduct procedures will apply as they will for all members of staff, for matters relating to professional concerns independent professional advice (not necessarily external) should be sought and any panel must include a member who is medically or dentally qualified and who is not employed by the organisation. However, whatever external advice is sought the decision still remains with the Trust as to what action should be taken.

MHPS Part IV indicates that cases concerning both conduct and capability should usually be combined under capability. This is not helpful when conduct issues predominate because, at present, capability proceedings are significantly more specialised and complex, with key legal cases bearing on them. However, the guidance allows, “there may be occasions where it is necessary to pursue a conduct issue separately.”

Managers and practitioners also need to avoid the potential mistake of classifying misconduct that has clinical consequences as capability. For example, rude and unpleasant behaviour in theatre will disrupt teamwork and may increase risks to patients. Similarly failure to follow clinical protocols may be due to inattention or disregard [behavioural problems, hence misconduct] rather than failing to recognise the clinical circumstances when they should be applied [clinical capability].

Determining the principal category of the concern is therefore important as not only does it inform process but also the organisation may be challenged or be subject to an injunction by the practitioner if the wrong procedure is applied.

In Wales although MHPS is not implemented the above consideration is helpful when considering action under WHC (90) 22.

2.5 Preparing to handle the concern

Generally, our experience is that the following factors can be a consideration when deciding which category might be appropriate:

- Deciding first whether health is the prevalent factor
- Reviewing whether matters of conduct and capability can rightfully be separated. For example, there is evidence of recent action being taken in regard to the conduct previously (for example a live warning or documented counselling) or the issues of capability are

minor, distinct and separate and as such they can be resolved through remediation
- Whether the concern arises from wilful, careless, inappropriate or unethical behaviour
- Whether the practitioner has disregarded matters which he/she of which he/she was aware, or could reasonably have been expected to make himself or herself aware (this is likely to be conduct)
- Inappropriate clinical practice arising from a lack of specialist knowledge or skills; for example, where a clinician has taken on work or new tasks for which he/she and, on occasion, the service in which they work, is inadequately trained or supervised. This may be accompanied by a lack of awareness into the concerns that employers may have in this regard
- Behaviour that contravenes the guidance in the GMC guide to Good Medical Practice may fall within the parameters of conduct and may justify referral to the GMC, in parallel with local action. *Referral to the Regulator does not preclude Performers List action around suitability. PCOs should make their own decisions as to whether they hold sufficient evidence to take action using Performers or Pharmaceutical List action independently of Regulator action*
- A persistent failure to engage with the performance management action and/or to accept the need for remediation may give rise to the matter being treated as conduct irrespective of the nature of the concern.

A further dimension may arise if the practitioner raises a counter complaint or a concern about clinical care, which may constitute a “protected disclosure” under the Public Interest Disclosure Act 1998; in other words, they could be considered a “whistleblower”. In these circumstances, any complaint or organisational concern brought forward by the practitioner should be treated consistently with the normal organisational procedures for reviewing concerns that are raised in this way and may not necessarily take precedence over any action the organisation may wish to take in response to the conduct matter. The two processes can run in parallel although there may be occasions when it is legitimate to conclude one investigation before embarking on the other.

In secondary care, medical managers and clinical tutors can expect to deal with behavioural problems on a regular basis. This will be even more common for HR managers and therefore it is important that whoever is involved in managing the concern maintains organisational consistency in the action taken.

In primary care, behavioural problems may be hidden within the practice setting and only come to light because of a serious incident, complaint or partnership dispute.

3. Engaging the practitioner

3.1 Responding to concerns[5]

When responding to a concern about behaviour or conduct, the employment and/or contractual relationship between the individual concerned and their organisation is important in determining the response and the subsequent action available.

For directly employed practitioners any action should be consistent with the relevant local procedures.

For primary care practitioners initial approaches to the practitioner about the concerns may need to be documented but informal, (in the sense that formal regulations may not be invoked initially) PCOs should be aware that both contractual and Performers List Regulations may be used. In secondary care, the structure of the approach should be framed around the requirements of MHPS in respect of doctors and dentists. The principles of MHPS may be equally applied in the case of pharmacists.

Initial action regarding performance may be taken by individual practices in respect of those doctors and dentists whom they employ or with whom they are in partnership although information regarding this would usually be expected to be passed on to the PCO as the holder of the Performers List if this did not resolve the concern. Serious concerns would normally be shared with the PCO from the start. In the case of sole contractors, the PCO may be involved at an earlier stage.

Once a concern becomes known, there are a number of factors that need consideration when developing a response. These include:

- Is there sufficient information to provide reasonable grounds for further action?
- Is the source of the information reliable?
- Does the issue immediately affect patient care or present a risk to staff?
- Who is the right person to take this forward?
- Who else needs to be involved?
- Is the practitioner aware of the concerns?
- Have there been previous concerns and, if so, how recently and what action was taken?
- Does the problem behaviour appear to come from one individual or could the concerns be a collective team matter?

While some of these issues may seem straightforward to address, they may be complicated by organisational factors such as a breakdown in relationships between the individual and their colleagues. In some instances, relationship breakdown may also affect those with a responsibility for addressing the concern, particularly where matters have become personalised.

As should be the case when handling any performance concern, it is important to ensure that case managers and investigators are impartial and are seen to be so by all parties. They must be sufficiently skilled to deal with the concern. There must be clear distance between those involved in the investigative process, including the reporting of this to the board members, and those who have a responsibility to hear and make decisions about the concerns if they proceed to a formal hearing.

3.2 Raising the concern with the practitioner

A discussion with the practitioner about the concern should take place at the first available

opportunity, except where this may relate to potential criminal or fraudulent acts where the Police or Counter Fraud Services may be leading on any enquiries.

In approaching any discussion, particularly where this may be the opening for difficult feedback, it may be helpful for the investigator to be accompanied and to advise the practitioner to have someone to attend with them. These discussions should be conducted in accordance with the correct local or national procedure. It is helpful in the initial discussion to set out:

- The intent and purpose of the meeting clarifying whether it represents a formal part of any process
- A description as far as possible (without being accusatory) of the areas of conduct or behaviours that have raised concerns supported by facts, observations and relevant documentation e.g. appraisals, records of Serious Untoward Incidents, letters of complaint., clinical audit findings, and feedback from Multi Disciplinary Team meetings.

The discussion also provides an opportunity to listen to, and give consideration to, the response of the practitioner. On conclusion of the meeting, there should be a clear understanding of any proposed action and this should be documented.
Sometimes feelings will be running high. From a manager's perspective, it is important to be able to attend appropriately to any emotional response without being derailed from the main purpose of the meeting. Problems are most likely where a manager is upset or angry about the perceived behaviour of the practitioner, especially if this leads to any sort of pre-judgment. It is important that the organisation takes a non-judgmental stance.

Recognising that the practitioner is likely to experience the complaint or allegation of misconduct as "bad news" it follows that managers should

- allow time for the information to sink in
- repeat key messages and confirm in writing
- ensure that the practitioner is accompanied
- ensure support is available and offered
- arrange a further meeting
- maintain regular communication with the practitioner – especially if they are suspended or excluded.

3.3 The practitioner's response

From a practitioner's perspective, it is important they keep in mind how difficult peers, other clinical staff, patients and relatives find it to raise such concerns. The practitioner will need to be encouraged to take time to register what is being said and talk it over with someone else before deciding on any response. It is important to emphasise, that while allegations of misbehaviour are inevitably personal, the actions of the employer or contractor are largely determined by policy and are usually impersonal.

The practitioner may need both emotional and practical support to help manage their feelings (particularly anger and shame) and to deal with the local investigation and what may arise from this Therefore robust professional support and representation is helpful and may avoid responses that are unhelpful and unproductive. Responsible managers should encourage practitioners to seek support from, for example, their defence body, professional association or local medical/dental/pharmaceutical committee.

Equally, a denial or non-acceptance by the practitioner of the matters raised does not invalidate genuine concerns that need action. Any dispute about the facts should not be allowed to escalate to an argument or impasse; both the organisation and the practitioner should have an opportunity to present their case fully to any subsequent hearing if this is warranted.

Any counter allegations by the practitioner should be fully investigated separately and robustly. This does not necessarily need to take place in advance of any current action about their conduct in accordance with the relevant local procedures. Regard will need to be given, however, about the extent to which the two investigations may overlap or if it is important to clarify the practitioner's complaint before proceeding with the conduct investigation.

Any action taken should be proportionate and reasonable in the circumstances of the concern and take account of the findings of the initial discussion. Where an individual has demonstrated some acceptance of the feedback and remorse for the difficulties created, the opportunity for improvement through a process of remediation may be greater and may avoid initially any requirement for formal action.

The approach taken will depend also on the nature and seriousness of the misconduct, the extent of the concern, whether there are genuine contributory factors (such as workload pressures) and the action that is required in order to maintain consistency in the application of local procedures. In this context, there may already be organisational precedents set that might inform a response.

In general, an individual can expect

- to be treated fairly and consistently
- where appropriate to be offered reasonable opportunity for remediation, particularly where there has been no previous cause for concern
- to receive a copy of the relevant performance management policies
- to have adequate opportunity to respond to the complaint/concern
- to be represented (at any stage of the process) and to call appropriate witnesses
- to receive all the information that will be relied upon to make a decision
- to appeal any decision if permitted within the process
- to take their case to an employment tribunal if they feel they have been unfairly treated.

An employer or contracting body is entitled to

- expect compliance with the contract
- expect appropriate standards of performance and conduct
- expect reasonable instructions to be followed
- safeguard patient safety and the welfare of staff
- investigate concerns
- share information about a performance concern where there is a duty of care to do so, including referral to the relevant regulatory body (the practitioner should be informed of this)
- take disciplinary action where appropriate
- dismiss where there are justifiable grounds for ending a contract.

In primary care, except in the case of a sole practitioner, several named persons will hold the contract. If the behaviour or conduct of one of these leads to a contractual breach then the remaining contract holders may deal directly with the poorly performing contract signee or may seek the advice of the PCO as to how to act.

For employees and non-contract holders action on performance concerns may be taken initially by the employer. Concerns are often escalated to the PCO for help when attempts at remediation fail or if the case seems so serious that either Performers' List action or referral to the regulator is indicated. NHS (Pharmaceutical Services) Regulations do not apply to employees so the only recourse is the employer or the regulator.

4. Looking at the evidence

It is important when considering the information available about the concern that this links to the standard of conduct that is felt to have been breached, rather than a subjective judgement assumed by the recipient. General statements (e.g. that someone is 'difficult' or 'challenging') do not provide a basis from which someone can change. Factual descriptions of the concerns and their impact, rather than emotive statements, will give the practitioner clarity on what they should aim for e.g. "When the practitioner deals with some of his patients he is brusque during clinical examination, which can make them upset" can be much more helpful. In primary care, this may relate more to regulatory standards depending on the individual practice policies.

The serious implications of disciplinary action require that full consideration is taken of all the available and relevant evidence of the facts. This should take into account the practitioner's circumstances, with regard to length of service, past performance, health and any further information necessary to inform a decision.

The evidence may therefore need to take account of aspects such as:

- health
- patterns of behaviour and conduct
- previous attempts at remediation
- whether the concerns are already subject to ongoing review or local action
- any "live" disciplinary warnings already in place/any current contractual breach notices
- particular situations that may trigger episodes of poor conduct
- complaints information
- attendance records
- job plan and other external commitments
- relevant organisational change that may be impacting on the situation
- work environment
- personal circumstances
- appraisal information.

The behaviours that are giving rise to the concern about conduct should be set out clearly with examples, including in what setting these have arisen, along with supporting evidence.

There may be a difference or misalignment of views between the practitioner and their employing/contracting organisation as to what constitutes or is defined by them as poor behaviour. Often it is the impact of the behaviour that provides the base for the concern; what is regarded as acceptable behaviour can differ from one individual to another. Where the impact of that behaviour has a detrimental effect on other colleagues or patient care it needs to be determined whether the conduct fell short of the relevant performance standard set by the organisation or the regulator. Even if the conduct does not fall short action may still be required to ensure that the practitioner's standard of behaviour is acceptable to colleagues and patients or, if there is no evidence of concerns, to consider whether the complaints are vexatious.

A practitioner who persistently refuses to accept that their conduct is in breach of acceptable standards or where there is evidence they have misrepresented the position in their account of events may mean that disciplinary action is inevitable. In these circumstances, there may be limited scope for remediation and regulatory action may be required as the practitioner's fitness to practise could be impaired.

Alternatively, while a practitioner recognises there is a performance deficit, this could still require further investigation as this may be only one indicator of a more widespread concern. For example, could an admission of an isolated failure to accept or follow a local clinical guideline mask a wider

and deeper failure to follow other local or national guidance to the detriment of patient care? It is always critical to understand whether what is seen is the extent of a problem or whether it represents the “tip of an iceberg”.

In most circumstances, an investigation is likely to be required to establish the facts and to provide clarity where there may be contradictory information. It is important for the terms of reference for the investigation to set out concisely the aspects of conduct giving rise to concern, with a clear description of the associated behaviour. They should not stray into unrelated areas, which may have caused irritation in the past, but are not part of the current episodes of poor performance.

The terms of reference should be shared with the practitioner for comment but not necessarily agreement. However, reasonable account should be taken of any disagreement about the scope of the investigation.

Where the concern is confined to one, relatively low-key event and there is no dispute about the facts, it may be possible to resolve the issue without a full investigation. However, deterioration in behaviour rather than a one-off event will require further investigation, particularly as a downturn in behaviour can link with poor clinical practice.

In addition, where the concerns are comprehensively refuted by other available evidence a full investigation may not be required. Nevertheless, there should be a documented audit trail of the discussions and outcomes along with any action so there is a clear understanding of what was agreed and the consequences of any repetition.

Further guidance is available in the NCAS publication *How to conduct a local performance investigation*.[6]

5. Management and resolution

5.1 Acting on the findings

Any action taken will depend on the findings of the initial review and discussion with the practitioner, and any subsequent investigation. Except in the cases of misconduct sufficiently serious to result in dismissal or, in primary care, removal from the relevant list, the premise of any action taken should be to support the individual in achieving a satisfactory and sustainable improvement in their conduct to enable them to work effectively alongside their colleagues. In some instances, setting out the areas that need improvement will be sufficient without the need for any further action other than monitoring and review.

The organisational response must also be demonstrably fair, consistent with the way all staff are treated in relation to the relevant local procedures and be mindful of precedents already set in this regard. It is important to inform the practitioner of the potential level of any formal action, particularly where dismissal or removal from the relevant list is a possible outcome, as they may be entitled to legal representation.

It should be clear what recourse there is if the practitioner has concerns about the handling of the process (for example, access to a Non Executive Director who under MHPS is required to have an overview of the process). Although MHPS does not apply in primary care, it is still good practice to involve a NED or lay person or equivalent person from within the new proposed structure for primary care.

If it is considered that despite a disciplinary sanction, the individual may have difficulty in modifying behaviour identified as unsatisfactory then, where remediation is appropriate, a judgement has to be made as to the form this should take. This should be based on the circumstances of each case as to what supporting action over and above any sanction is required to help the individual to prevent a further recurrence of the misconduct.

A disciplinary warning may be conditional on certain undertakings such as attending specific training or entering into a behavioural contract, which would set out explicitly the unacceptable behaviours the individual must avoid. It would include a commitment from the individual to improve their conduct over a given time and the consequences if there is no improvement.

Any written warning should set out the reasons for the warning clearly and should be explicit as to what will happen if there is a repetition of the specific misconduct this relates to or any other type of misconduct within the period of the warning.

In some instances, the individual concerns may also be affected by the dynamics and working relationships within the practitioner’s team. Any wider concerns may also require review or organisational support. This will avoid placing the individual back into a potentially toxic environment, which may give rise to the same difficulties occurring again because the wider team aspects have not been addressed.

In primary care, disciplinary warnings may be issued in line with practice disciplinary policies or conditions may be placed upon the practitioner using Performers or Pharmaceutical List Regulations. PCOs should be aware that conditions can only be attached in cases where the PCO has enough evidence to justify a removal from the list which action can then be mitigated by the imposition of conditions. If there are insufficient grounds for initial removal then the PCO may consider voluntary agreement to conditions. These can be complex matters to address that take a long time to resolve. There may need to be an amnesty period to allow the practitioner reasonable time to modify behaviour through support and training. Habits and behaviour that have taken a lifetime to form will not change overnight and may require structured support and development.

5.2 Useful tools

There are a number of routes in to supporting a practitioner and an NCAS assessment of behavioural concerns can provide an independent perspective and further information about the behaviours and the possible drivers for these. In addition to thorough psychometric assessment and interview with an experienced occupational psychologist, which is informed by multi-source feedback information, the process also includes a full occupational health assessment.
The combined information can help to inform an action plan to support personal improvement. This is very much a self-directed process and relies on the understanding, engagement and commitment of the practitioner to work through a detailed programme of explicit and time limited objectives. Depending on the scope and content, an action plan may entail costs say in personal coaching. Who takes responsibility, including financial responsibility for these needs to be agreed at the outset.

Other useful tools include

- a behavioural contract
- coaching
- skills-based training.

NCAS advisers can advise on the use of all of the above and the development of action plans.

The overall costs of remediation can be significant and therefore early action is essential in helping to resolve the concern and in curtailing the financial impact of not addressing the problem.

Where the practitioner is employed or contracted to work subsequently, relevant and appropriate information about the action taken including remediation and temporary restriction to practise should be made available to those other employers or contractors.

Further information is available from NCAS' *Back on track Framework for further training.*

5.3 Intractable cases

In some cases, the process of managing performance may have affected relationships to the point where attempting remediation may be difficult or where there remains a divergence of views about what may have precipitated any informal/formal action. At this stage, a mediated discussion, managed by a neutral individual, may give both parties the opportunity to air any residual thoughts or feelings and provide a platform from which to proceed on a developmental basis. NCAS has experience of facilitating this style of discussion where it would be appropriate to do so.

In other instances, some differences between the parties may be irreconcilable particularly if one of the parties feels alienated from the other.

5.4 Contacting NCAS

Dealing with behavioural performance concerns is very difficult but NCAS has over ten years' experience of supporting their resolution. Senior managers working at a local level may have varying levels of experience in this area and we are here to help. Contacting us soon after a concern has been identified may mean that it is resolved before regulatory action is needed. Our advice is therefore to contact us as early as possible. We respond to calls about any aspect of individual or team behaviour and conduct, even where it is not yet clear whether there is evidence of poor practice. Our contact details are on our website.

Annex

Poor performance – evidence and experience

Research evidence

The NCAS 2011 Annual Conference, *Disruptive behaviour – Tackling concerns about practitioner behaviour*, presented a selection of the growing body of evidence on behavioural concerns in practitioners from Europe and North America.

Five broad personality traits – the ‘Big Five’ - influence our behaviour:

- Emotional Stability – How resilient?
- Extraversion – How sociable?
- Openness – How open to new experiences and change?
- Agreeableness – How collaborative?
- Conscientiousness – How diligent and focussed?

The extent to which an individual exhibits each of these traits, combined with the environment they are in, will influence their behaviour.[7]

Practitioners displaying poor behaviour can be extremely disruptive. Clinical professionals may be autonomous but they never work in isolation and can cause alarm, distress and anger in those working around them and their patients if they behave badly. Behavioural concerns, once identified, should be addressed early.

Other than personality traits, a number of important factors have been identified that can influence behaviour:

- Chronic embitterment – described as being “An emotion encompassing persistent feelings of being let down, insulted or being a loser, and of being revengeful but helpless” can be particularly difficult. Responsible managers may see difficult behaviours arising from practitioners who feel resentful over an incident in the workplace e.g. a fall out with a member of their team, their reaction to having clinical concerns addressed or feeling they are not being listened to when they have concerns about something or someone.[8]
- Team behaviour – a poor balance of individual and team needs e.g. a divergence of individual and team learning and development needs can lead to both individual and team dysfunction.[9]
- Clinical managers’ behaviour – the difficulties that many clinical managers experience being asked to take on a role that they have not had the same breadth of training for as their clinical profession can influence how members of their team behave.[10]
- Cultural background – the unspoken rules of interaction in the NHS at national, organisational and team level can be difficult for a practitioner who is used to working in a different way. Their attitude to rules, relationships and how to interact with others may be different.[11]
- Health and behaviour.[12]

NCAS experience

When cases are referred to NCAS, NCAS staff summarise and record the concerns raised after discussion with the referring manager. Of the 927 cases handled by NCAS during the 2010/11

financial year, 59% were recorded as having some sort of behavioural component, either with or without other concerns.

Behavioural difficulties in practitioners who are referred to NCAS include:

- Communication with colleagues
- Team working
- Communication with management
- Communication with patients, carers, relatives
- Aggressive behaviour
- Behaviour under pressure
- Conflict management style
- Leadership style
- Decision-making style
- Erratic/unpredictable behaviour
- Withdrawn/isolated behaviour

These are terms used by NCAS when a practitioner is referred to NCAS, based on what NCAS advisers are told by responsible managers. The list should be seen as indicative rather than exhaustive. However, it shows the range of behavioural difficulties that practitioners are displaying. Practitioners may be referred with a combination of behavioural concerns.

Agreeable practitioners

Problem behaviours may not be immediately obvious. Although it is easy to identify a practitioner who is consistently rude and aggressive towards colleagues as having problem behaviour, some agreeable traits can cause difficulties in the workplace as well. A personality profile analysis of 279 practitioners referred to NCAS produced some unexpected results. Although some of the personality traits we expected were present, some findings were counterintuitive:[13]

What we expected	*What we found*
More emotionally reactive	Somewhat more reactive
More introverted	More introverted
Less open	Less open
Less agreeable	Much MORE agreeable
Less conscientious	Similar to the working population
Under pressure: More arrogant	Under pressure: More perfectionist and more dependent (anxious to please)

Some of these traits may make managing performance concerns difficult. Practitioners who are very agreeable may find it hard to be assertive when dealing with problems in their practice. It can be a practitioner’s desire to do a job well and particularly to please their patients that means their behaviour causes conflict with others.

Endnotes

[1] As at financial year end 2010/11. See *2010/11 Casework activity report*. NCAS. 2011.
[2] *Guidebook for managing disruptive physician behaviour*. College of Physicians and Surgeons of Ontario. 2008.
[3] *NCAS Casework: The first 8 years*. NCAS. 2009.
[4] See the NCAS good practice guide *The Back on Track Framework for further training: Restoring practitioners to safe and valued practice* for more guidance on remediation. NCAS. 2010.
[5] See also the NCAS good practice guide *How to conduct a local performance investigation*. NCAS. 2010.
[6] *How to conduct a local performance investigation*. NCAS. 2010.
[7] *Disruptive behaviour – symptom, cause or both?* Dr Gwen Adshead, Dr Deborah Bowman, Dr Jenny King and Professor Alastair Scotland. NCAS Annual Conference 2011: Disruptive behaviour – Tackling concerns about practitioner behaviour.
[8] *Behaviour and embitterment.* Dr Rosemary Field, Ms Claire McLaughlan and Professor Tom Sensky. NCAS Annual Conference 2011.
[9] *Behaviour in teams*. Ms Lynn Markiewicz, Mr William Rial and Mrs Chris Wilkinson. NCAS Annual Conference 2011.
[10] *Bridges or barriers? Impact of clinical managers' behaviour on practitioner behaviour*. Mr David Evans, Dr Megan Joffe and Professor Pauline McAvoy. NCAS Annual Conference 2011.
[11] *Cultural background – impact on behaviour*. Dr Janine Brooks and Dr Debbie Cohen. NCAS Annual Conference 2011.
[12] Health and behaviour. Dr Nick Brown, Dr Peter Dickson, Ms Florence Starr and Mrs Elaine Stevenson. NCAS Annual Conference 2011.
[13] *Personality of doctors in difficulty: Analysis of 120 behavioural assessment cases from NCAS (UK)*. NCAS, Edgecumbe Group, Personnel Assessment Ltd. 2006.

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