The Dudley Group
NHS Foundation Trust

Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

Ref: FOI-062024-000938

Date: 13/06/2024

Address / Email:

Dear

Request Under Freedom of Information Act 2000

Thank you for requesting information under the Freedom of Information Act 2000.

Request

Dear Medical Director/Director of Human Resources

As you are aware Maintaining High Professional Standards framework (hereinafter referred to as MHPS) sets out the process for all NHS employers to follow in handling concerns about the conduct, performance, and health of medical and dental staff.

I am writing to you to request specific information under the Freedom of Information Act regarding concerns the BMA have that medical and dental staff from an ethnic minority background are more likely to be subjected by employers to a MHPS process.

In order that we may explore this further and consider next steps, we do require specific information pertaining to this and therefore, are requesting that you provide the following information:

1. Please confirm has your Trust adopted the Just Learning Culture in handling of concerns following receipt of Dido Harding's letter that was sent to all Chairs and Chief Executives of NHS Trusts and NHS Foundation Trusts dated 23 May 2019.

2.Does your MHPS Procedure set out an informal process to deal with concerns pertaining to conduct/ capability of medical and dental staff, if so please provide details.

3.Please provide details of what training and support is provided by your Trust to Case Investigators and Case Managers when dealing with MHPS cases.

4.Please can you confirm if your Trust has a Decision-Making Group and if so please can you confirm who sits on this group/how this is constituted and its remit?
Please provide a breakdown of the requested information below for the period from May 2019 to date:

5. The number of cases of medical and dental staff that were handled and resolved via a Just Culture approach and informal process.

6. The number of cases of medical and dental staff that were subjected to a formal MHPS investigation.

7. The number of medical and dental staff that have been formally excluded under MHPS and the duration of the exclusion.

8. Where medical and dental staff have been formally excluded under MHPS please provide a breakdown of whether this was on grounds of a) a need to protect the interests of patients or other staff pending the outcome of a full investigation, and/or b) the presence of the practitioner in the workplace was likely to impede the gathering of evidence during the investigation?

Response

1. Please confirm has your Trust adopted the Just Learning Culture in handling of concerns following receipt of Dido Harding's letter that was sent to all Chairs and Chief Executives of NHS Trusts and NHS Foundation Trusts dated 23 May 2019.

   Yes confirmed.

2. Does your MHPS Procedure set out an informal process to deal with concerns pertaining to conduct/ capability of medical and dental staff, if so, please provide details.

   Yes, please see policy attached.

3. Please provide details of what training and support is provided by your Trust to Case Investigators and Case Managers when dealing with MHPS cases.

   The Trust uses NHS Resolution for training.

4. Please can you confirm if your Trust has a Decision-Making Group and if so, please can you confirm who sits on this group/how this is constituted and its remit? Please provide a breakdown of the requested information below for the period from May 2019 to date:

   Yes, Medical Concerns is the Decision-Making Group – terms of reference within the policy as an appendix. Note this is currently being reviewed.

5. The number of cases of medical and dental staff that were handled and resolved via a Just Culture approach and informal process.

   67

6. The number of cases of medical and dental staff that were subjected to a formal MHPS investigation.

   43

7. The number of medical and dental staff that have been formally excluded under MHPS and the duration of the exclusion.

   As per NHS Digital rules the Trust does not publish numbers lower than 5 as this could lead to the identification of the persons involved and cause distress to Families or Friends. The number of medical and dental staff that have been formally excluded under MHPS and the duration of the exclusion requested is less than 5, therefore Exemption Section 40(2) of the Freedom of Information Act is applied.

8. Where medical and dental staff have been formally excluded under MHPS please provide a breakdown of whether this was on grounds of a) a need to protect the interests of patients or other staff pending the outcome of a full investigation, and/or b) the presence of the practitioner in the workplace was likely to impede the gathering of evidence during the investigation.

   N/A

If you are dissatisfied with our response, you have the right to appeal in line with guidance from the Information Commissioner. In the first instance you may contact the Information Governance Manager of the Trust.

Information Governance Manager
Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ
Email: dgft.dpo@nhs.net

Should you disagree with the contents of our response to your appeal, you have the right to appeal to the Information Commissioners Office at.

Information Commissioners Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113
www.ico.org.uk

If you require further clarification, please do not hesitate to contact us.

Yours sincerely

Freedom of Information Team
The Dudley Group NHS Foundation Trust

NHS
The Dudley Group
NHS Foundation Trust

MANAGEMENT OF CONDUCT AND CAPABILITY FOR MEDICAL AND DENTAL STAFF POLICY		
	DOCUMENT TITLE:	**MANAGEMENT OF PROFESSIONAL CONDUCT AND CAPABILITY FOR MEDICAL AND DENTAL STAFF POLICY (MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN NHS)**
	Name of Originator/Author /Designation & Specialty:	[redacted] Head of Operational HR
	Director Lead:	Chief People Officer
	Target Audience:	All The Dudley Group NHS Foundation Trust Doctors and Dentists
	Version:	Version 2.1
	Date of Final Ratification:	December 2020
	Name of Ratifying Committee:	Quality and Safety Committee
	Review Date:	December 2023
	Registration Requirements Outcome Number(s) (CQC)	Safe, Effective, Caring, Well Led
	Relevant Documents /Legislation/Standards	"Maintaining High Professional Standards in the Modern NHS" issued under the direction of the Secretary of State for Health on 11 February 2005. https://improvement.nhs.uk/documents/2490/NHS_0932_JC_Poster_A3.pdf
	Contributors:	**Designation:** Medical Leads Staff Side Representatives
	The electronic version of this document is the definitive version	

CHANGE HISTORY

Version	Date	Reason
V1.0	May 2011	This is a new document
V1.1	April 2018	6 month extension given at Policy group – to be reviewed in November 2019
V1.2	November 2018	3 month extension to review date
V1.3	February 2019	6 month extension – change in legislation
V1.4	August 2019	6 month extension – change in legislation
V2.0	December 2020	Full revision and reissue and inclusion of the Remediation and Support for Medical Staff Policy
V2.1	May 2024	Amended Anti-Discrimination statement and added links to staff network stance, changed to gender-neutral language

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

Contents Page

THE DUDLEY GROUP NHS FOUNDATION TRUST

MANAGEMENT OF CONDUCT AND CAPABILITY FOR MEDICAL AND DENTAL STAFF POLICY

GUIDING PRINCIPLES:

When dealing with concerns raised in relation to medical and dental staff the following principles must be applied:

- Patients must be protected.
- Clinicians too must be safeguarded.
- All action must be based on reliable evidence.
- The process must be clearly defined and open to scrutiny.
- The process should demonstrate equality and fairness.
- All information must be safeguarded.
- Support must be provided to all those involved.

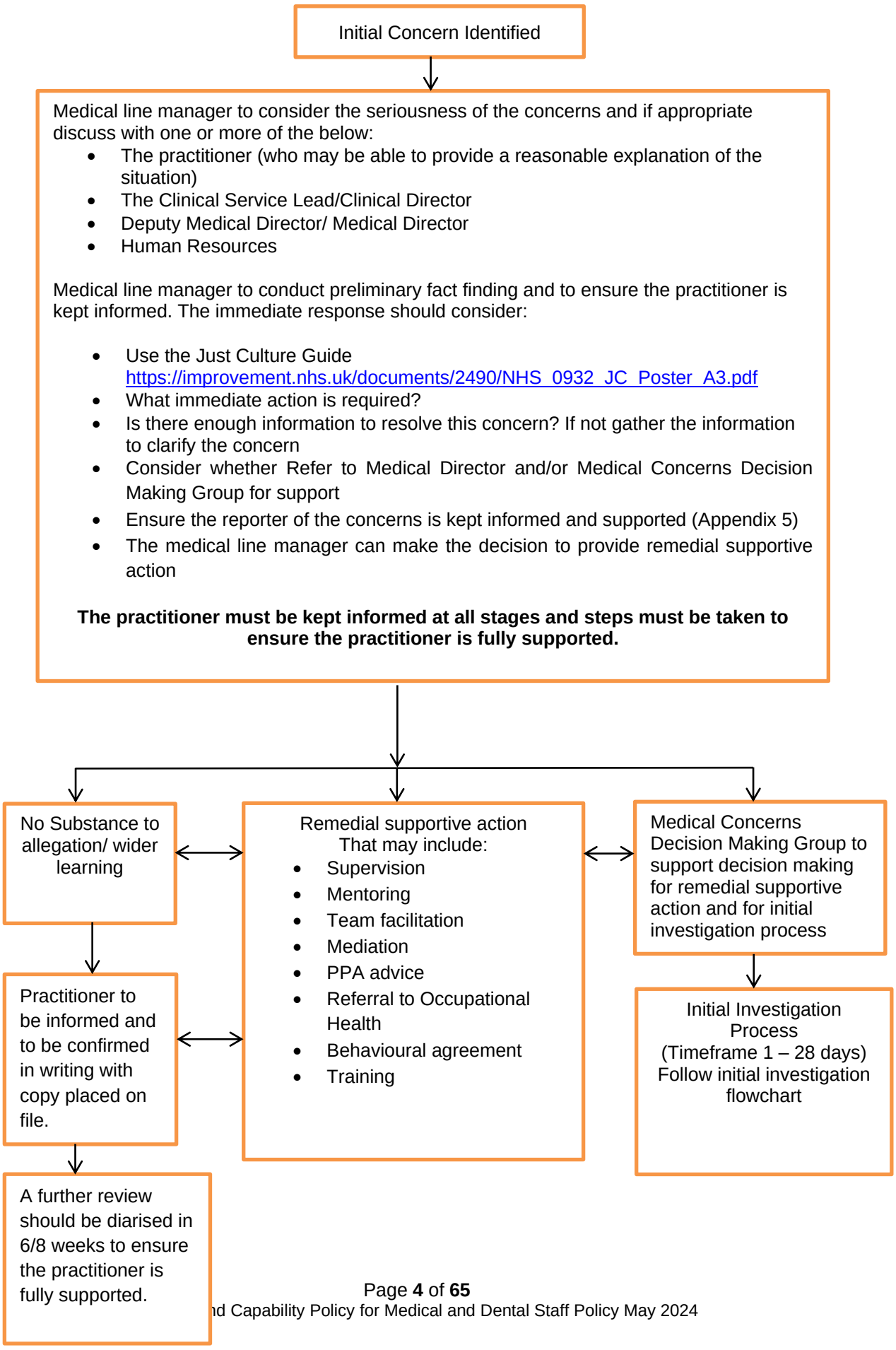
PROCESS FLOW CHARTS

Flow charts for the Management of Professional Conduct and Capability for Medical and Dental Staff. The purpose of the flowcharts is to guide the user through the policy;

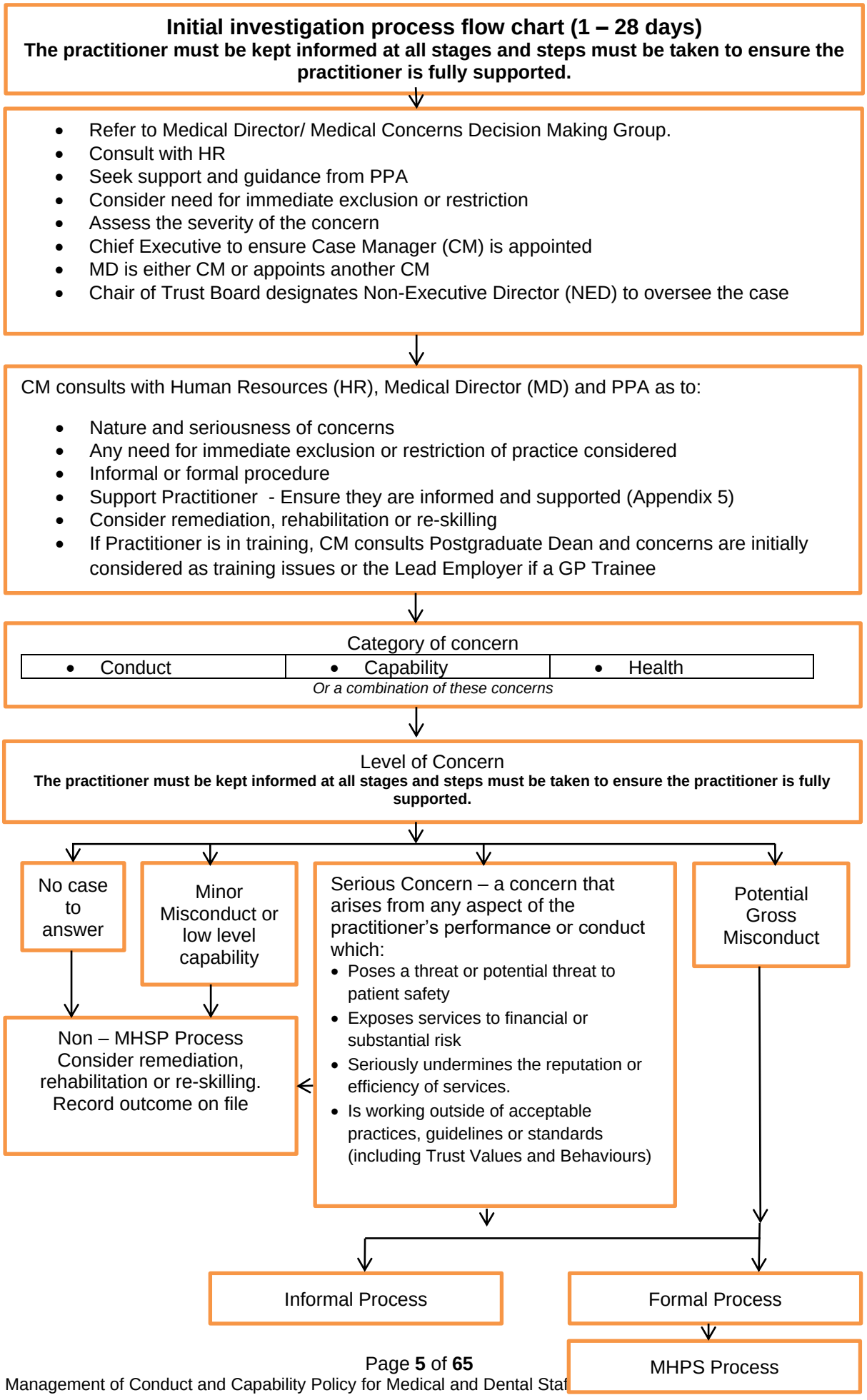
- Allegation of concern(s) process flow chart – Immediate Actions.
- Initial Investigation process flow chart (1 – 28 days).

In addition, at any stage of the handling of a case consideration should be given to the involvement of the Practitioner Performance Advice (PPA).

Allegation of concern(s) process flow chart



Initial investigation process flow chart (1 – 28 days)



1 INTRODUCTION

1.1 The Dudley Group NHS Foundation Trust is committed to ensuring that concerns in relation to the conduct and capability of doctors and dentists are dealt with in a fair and consistent manner, in line with the national framework "Maintaining High Professional Standards in the Modern NHS" issued under the direction of the Secretary of State for Health on 11 February 2005. This is an agreement between The Dudley Group NHS Foundation Trust and the Joint Local Negotiating Committee (JLNC) outlining the employer's procedure for handling concerns about doctors' and dentists' conduct and capability.

1.2 The Trust, recognising the honesty and integrity of its staff, believes that personal and professional conduct should be largely self-regulated. The Trust accepts that breaches of the rules of conduct and standards of performance will occur from time to time. The Trust expects to deal with these breaches firmly but with sensitivity. Breaches should, wherever appropriate, be dealt with informally in the first instance. A number of mechanisms exist for potential problems to be addressed by the medical and dental profession at an early stage on a colleague-to colleague basis.

1.3 The Trust is committed to using a Human Factors approach to patient safety incidents. The vast majority of people who work in health and social care want to provide the very best care they can, but sometimes things do not go as expected or planned.

Despite best individual efforts, staff training and the use of technology, mistakes will happen. To learn from these events, we can look at why those mistakes happened and, using a human factors approach, we can prevent not only that particular event happening again, but also other similar events happening in the future.

1.4 This policy and procedure applies to all doctors and dentists (referred to as the "practitioners") employed by the Trust. These procedures supersede all previous Trust and Department of Health procedures including HC90 (9), HC (82)13, HSC (94)49 and HM (61)112 in respect of their application to practitioners employed by the Trust.

1.5 The policy provides comprehensive steps and principles for dealing with concerns raised regarding doctors and dentists and to enable prompt and appropriate action to be taken in the interests of patients, staff and the practitioner.

1.6 This policy applies to all medical and dental staff, including consultants, doctors and dentists in training and other non-training grade staff employed by the Trust e.g. salaried GPs and GPs employed on a sessional basis and has been designed to give consistent and fair treatment to all. Where formal disciplinary action is used, it should emphasise and encourage improved standards of performance/conduct. It is not a means of punishment.

Agency and bank locum medical and dental staff are not subject to this policy as they are not directly employed by the Trust.

1.7 Practitioners who are subject to the formal procedures in this document will be provided with a summary of rights (Appendix 4). At any stage of this process – or subsequent disciplinary action - the practitioner may be accompanied in any interview

or hearing. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body, an official or representative of the British Medical Association [or any other recognised trade union], British Dental Association or a defence organisation, or work colleague, a friend, partner or spouse. The companion may be legally qualified but they will not be acting in a legal capacity.

1.8 It should be noted that different rights apply in processes administered by other agencies (for example police and the Counter Fraud Service). The procedures operated by these agencies are governed by legislation over which the Trust has no control.

1.9 It is recognised that it may be appropriate on occasions, after consideration by the Medical Director (MD), Human Resources or Chief Executive (CE), to inform the General Medical Council (GMC), General Dental Council (GDC), Practitioner Performance Advice (PPA) and other outside agencies about issues dealt with under these procedures.

1.10 A commitment to equality, diversity, and inclusion is fundamental to the core values of Dudley Group NHS Foundation Trust. We want everyone to feel safe and valued and that they belong. Everyone must feel respected, included, and treated fairly so they are confident to be themselves at work and develop their skills as part of a great team.

We are strongly committed to actions that build an inclusive environment where opportunities are open, diversity is valued, and everybody can reach their full potential without fear of harassment, prejudice, or discrimination. We want to make clear that as an NHS organisation, we will not tolerate unacceptable behaviour, including bullying, harassment, victimisation, discrimination, or violence based on any protected characteristic. It will be taken seriously and handled appropriately under relevant policies and procedures.

We further declare our commitment to working alongside our staff networks to become an anti-discrimination organisation, for further details please click the following link: Anti-discrimination - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

If you have experienced bullying, harassment, victimisation, discrimination, or violence, you must report it. How To Report

2 STATEMENT OF INTENT/PURPOSE

2.1 This policy is taken from the national framework developed by the Department of Health, the NHS Confederation, the British Medical Association and the British Dental Association and applies to the NHS in England. It covers:

- action to be taken when a concern about a doctor or dentist first arises
- procedures for considering whether there need to be restrictions placed on a post, a doctor or dentist's practice or exclusion is considered necessary
- guidance on disciplinary procedures and conduct hearings
- procedures for dealing with issues of capability
- arrangements for handling concerns about a practitioner's health.

2.2 This process covers matters on clinical performance, capability and professional misconduct. Matters of personal misconduct will be dealt with under the Trust's standard disciplinary procedure.

2.3 The policy applies to all Medical and Dental staff employed by the Trust. Whilst this policy can be applied to honorary Consultant staff, it is normally the case that the employing organisation will inherit and manage the process, in conjunction with the Trust that had the honorary contract.

2.4 This policy is intended to encourage and support doctors and dentists in achieving and maintaining high professional standards. It has been devised to reflect the framework set out in HSC2003/012 "Maintaining High Professional Standards in the Modern NHS".

2.5 The management of performance is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to disciplinary procedures.

Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:

- concerns expressed by other NHS professionals, health care managers, students and non-clinical staff
- review of performance against job plans, annual appraisal, revalidation
- monitoring of data on performance and quality of care
- clinical governance, clinical audit and other quality improvement activities
- complaints about care by patients or relatives of patients
- information from the regulatory bodies
- litigation following allegations of negligence
- information from the police or coroner
- court judgements.

2.6 Where there is an allegation of misconduct or concern raised regarding performance in relation to a doctor in training, then the Director of Medical Education should be informed so that the Postgraduate Dean at Health Education England can be notified to ensure their involvement from the outset. Concerns about the capability of doctors and dentists in training should be considered initially as training issues.

2.7 Unfounded and malicious allegations can cause lasting damage to a doctor's reputation and career prospects. Therefore all allegations, including those made by relatives of patients or concerns raised by colleagues, must be properly investigated to verify the facts so that the allegations can be shown to be true or false. It therefore follows that careful judgement is required to apply the following processes.

3 DEFINITIONS

Conduct	Where the conduct or behaviour of a doctor or dentist: □ falls below that expected as set out in *GMC Good Medical Practice (2013)* as amended, http://www.gmc-uk.org/guidance/good_medical_practice.asp and/or

	□ is not consistent with the Trust's value and behaviours
Capability	Where there is evidence of clinical practice outside that which is regarded as 'standard and acceptable' by a body of specialty opinion, e.g. NICE, and/or has implications for patient safety. Opinion can be drawn from both internal sources, e.g. colleagues within the specialty, and external sources (particularly when there might be conflict of interest) such as clinicians from the same specialty working in other Trusts or Royal Colleges.
Continuous Professional Development	Encouraging practitioners to maintain skills and knowledge through processes, including appraisal and revalidation.
Practitioner Performance Advice (formerly the National Clinical Assessment Service, NCAS)	Practitioner Performance Advice (formerly the National Clinical Assessment Service - NCAS) is now a service delivered by NHS Resolution under the common purpose to provide expertise to the NHS on resolving concerns fairly, share from learning for improvement and preserve resources for patient care. The PPA provides a range of core services to NHS organisations such as advice, assessment and intervention training courses and other expert services.
NHS England & NHS Improvement (NHSEI)	Now incorporates the former National Patient Safety Agency (NSPA) which ***leads*** and contributes to improved safe patient care by informing, supporting and influencing the health sector.
Root Cause Analysis	Examining causes of failure in standards of care – often problems are due to weaknesses in systems as opposed to the fault of an individual.
Human Factors	Human Factors principles should be applied in the identification, assessment and management of patient safety concerns, and in the analysis of incidents to identify learning and corrective actions.
Medical Concerns Decision Making Group	A decision making group to manage the interface between the business units and Medical Director. This group will consist of: • Medical Director/Deputy Medical Director • Chiefs of Service (Directorates) • Human Resources
Just Culture Guide	**Just Culture Guide** The Just Culture approach supports consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. All practitioners are fallible and mistakes and errors will be made. The Just Culture Approach (Appendix 7) provides a clear framework to assess whether a patient safety incident requires specific individual investigation and support, or identifies an organisational issue that requires wider actions. This approach protects staff and patients by ensuring that wider

	patient safety issues are addressed as organisational, rather than as individual issues. The Just Culture Guide can be used at any point of the investigation, and may need to be revisited if more information becomes available. • https://improvement.nhs.uk/documents/2490/NHS_0932_JC_Poster_A3.pdf
Alert Letter	An Alert may be issued to prevent or avoid unexpected or avoidable death, harm or injury to patient, carer, staff or visitor, or in order to prevent fraud. Alerts can be cascaded throughout the NHS, and are directed, on a necessary and proportionate bases, to any relevant team within (or outside) NHS England. When Alerts are sent to relevant people they may include action to be taken, or raise awareness of potential harm to which staff need to be aware.

4 DUTIES (RESPONSIBILITIES)

4.1 TRUST BOARD AND DESIGNATED MEMBER

Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the policy is being followed. Only the designated Board member should be involved to any significant degree in each review.
The Board is responsible for designating one of its non-executive members as a "designated Board member" under this policy.

The Trust Board is responsible for:

- ensuring these procedures are established and followed
- ensuring the proper corporate governance of the organisation
- Designating one of its non-executive directors (NED) members as the "Designated Board Member" when a serious concern arises.

The Board must be informed about any exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. Therefore:

- a summary of the progress of each case at the end of each period of exclusion will be provided to the Board, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible
- a quarterly statistical summary, showing all exclusions with their duration and number of times the exclusion has been reviewed and extended, will be provided with a copy sent to NHS Improvement.

4.2 CHIEF EXECUTIVE OFFICER

The Chief Executive has ultimate accountability for the Trust's Disciplinary and Management of Performance for Medical and Dental Staff Policy. Operational responsibility is delegated to the Medical Director.

4.3 MEDICAL DIRECTOR

The Chief Executive has ultimate accountability for the Trust's Disciplinary and Management of Performance for Medical and Dental Staff Policy. Operational responsibility is delegated to the Medical Director.

The Medical Director is responsible for:

- the practical implementation of this policy ensuring that cases of individual conduct and capability are managed fairly and promptly

- deciding on the category and level of concern (involving Medical Concerns Decision Making Group (MCDMG) as appropriate)

- deciding on the course of action required and who else to involve, e.g.:
  - convening a meeting, as appropriate, of the MCDMG group to discuss the Issues or

  - commissioning a fact finding process, the aim of which is to gather enough information to help inform and rationalise whether the issue can be dealt with informally or needs to be addressed via the formal procedure

- recording the decision whether or not to investigate when not the case manager, appointing a case manager and/or case investigator (via the Medical Concerns Decision Making Group (MCDMG) as appropriate)

- The Medical Director will act as the case manager in cases involving clinical directors and consultants or will delegate this role to a senior clinical manager

- agreeing/writing the terms of reference for an investigation or delegating this to the case manager (Appendix 6)

- considering practice restriction/exclusion, to ensure that exclusion from work is done only where absolutely necessary, and that exclusion periods are kept to a minimum

- referral to the regulator, involvement of other external agencies, duty of candour, discussion with PPA, immediate health intervention, support of the individual, including through professional representation and OH support, and confidentiality

- considering the result of the investigation report and recommending any further action to the Chief People Officer on conclusion of the investigation.

4.4 DESIGNATED BOARD MEMBER (NED)

Designated Board Member is a non-executive director of the Trust who ensures that the processes set out in these guidelines are being followed but does not make decisions on any issues such as whether to exclude from work. The designated Board Member must also ensure, amongst other matters, that the process and time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights (the right to a fair trial)

They:

- Receive regular reports from the case managers on the number, progress and outcome of investigations and exclusions of medical practitioners

- Oversee the cases, to ensure that the investigation is being carried out promptly and in accordance with these guidelines. A summary of the progress of each case will be provided, demonstrating that policies are being correctly followed, and that all reasonable efforts are being made to resolve the situation as quickly as possible

- Act as a point of contact for the practitioner, making themselves available after due notice if the practitioner has significant concerns about the progress of the investigation or any exclusion from work.

4.5 CASE MANAGER

The following are authorised by the Trust to act as case managers:

- The Medical Director
- Deputy Medical Director
- An appropriate Clinical Director appointed by the Medical Director (in a case not involving a Consultant)
- Any Medical Director or Clinical Director not employed by the Trust who has been requested to undertake this role by the Chief Executive of the Trust.

The case manager must be experienced and/or appropriately trained and has the responsibility for overseeing investigations into concerns about a practitioner. Their duties are to:

- On first hearing about these concerns needing to decide whether they should be formally investigated.

- Ensuring the practitioner must be notified in writing at the commencement of any and every formal investigation into their conduct or capability

- Consider (usually with the Chief People Officer and Chief Executive) whether to immediately restrict a practitioner's duties or exclude him/her from work or take some other form of protective action.

- Monitor the investigation timescales, with a view to the investigation being completed within a 3-month period, unless there is a valid reason for the investigation to extend past this point.

- Upon receipt of the case investigator's report consider whether a formal procedure should be started (for instance a disciplinary hearing). At this stage, they will also consider whether any immediate restrictions or exclusion should be continued.

- Review any exclusion and determine whether it should be continued.

- Prepare reports on each exclusion before the end of each four week exclusion period and ensure these are submitted to the Non-executive Director.

- Liaise with and seek the advice of the Practitioner Performance Advisory Service (PPS – Formerly NCAS) as set out in this policy.

4.6 CASE INVESTIGATOR

The following are authorised by the Trust to act as case investigators:

- Clinical and Non-Clinical Directors
- General Managers
- Operational Service Managers
- Heads of Department

This list is not exhaustive and the Trust can authorise an individual not within the list as a case investigator if deemed appropriate. The case investigator must be experienced and/or appropriately trained and will be given appropriate time to complete the investigation.

The case investigator is the person who is responsible for carrying out a formal investigation into concern(s) about a practitioner. They:

- Must carry out a proper and thorough investigation into the concerns.

- Involve an appropriately qualified clinician to investigate clinical concerns if they have such qualifications.

- Ensure that appropriate witnesses are interviewed and evidence reviewed.

- Ensure that any evidence gathered is carefully and accurately documented.

- Ensure the investigation is completed within a 3 month period, unless there is a valid reason for the investigation to extend past this point.

- Keep a written record of the investigation, the conclusions reached and the course of action agreed with the Medical Director and Chief People Officer.

- Meet with the practitioner in question to understand the practitioner's case.

- Prepare a report at the conclusion of the investigation providing the case manager with enough information to decide how to take it forward.

- Provide updates and assistance to the Designated Board Member on the progress of the investigation.

- Provide factual information to assist the case manager in their review of any exclusion.

- Ensure adequate safeguards for confidentiality.

4.7 CLINICAL ADVISER

The Clinical Adviser is the person who provides clinical advice and guidance to the case investigator if relevant where clinical issues arise. They will have appropriate specialist skills to advise. Where no such person is available or is precluded from advising (for instance if they raise the concern) the Trust will seek to identify a person outside its employment to advise.

4.8 MEDICAL / DENTAL MANAGERS

Managers must ensure that their staff know the standards of work and conduct required, that adequate training is given, and that staff are kept informed of their progress in meeting the required standards. Managers should also ensure that staff receive regular 1:1 meetings and a performance review.

Clinical Line Managers are responsible for:

- Ensuring practitioners are aware of the standards of conduct expected of them
- Providing help and support to assist their staff in achieving and maintaining these standards
- Carrying out the initial fact-finding process, to identify the nature of the problem or concern, and to assess the seriousness of the issue and whether or not it can be resolved informally
- To ensure that practitioners are supported through the process, and given an opportunity to give their own account of the concern at the earliest possible stage
- Ensuring that the practitioner is kept informed of any allegations, and is informed of the outcome of the initial fact-finding process
- Ensuring that the reporter is informed of the outcome of the fact-finding process
- Promptly dealing with issues of minor misconduct or poor performance
- Ensuring the Medical Director is promptly made aware of any issues of misconduct or poor performance, requiring their attention, as appropriate
- Ensuring any concern related to patient safety is acted on immediately within a clinical framework, including Duty of Candour and informing commissioners/HLRO/NHSI as appropriate

4.9 ROLE OF THE MEDICAL CONCERNS DESCISION MAKING GROUP (MCDMG)

The Medical Concerns Decision Making Group, chaired by the Medical Director or their appointed deputy, will be convened to discuss and advise the Medical Director about the approach to be adopted in a specific case.

Membership will vary dependent upon the issue and the specialty involved but could include:

- Medical Director
- Deputy Medical Director
- Human Resources Representative
- Chiefs of Service

Where appropriate it could also include:

- Relevant Clinical Director
- Safeguarding
- Occupational Health

All formal investigations into medical and dental staff, and all decisions for exclusions should be discussed within this group, and these decisions should not be taken in isolation

The Terms of Reference for this group are enclosed at Appendix 1

4.10 STAFF

All Medical and Dental staff need to be aware of the standards of work and conduct required of them and to work with managers in the application of this policy.

Every doctor has a professional duty to maintain their fitness to practise. This includes the duty to be proactive about raising a concern about their practice, to acknowledge a concern if one is raised and to engage constructively with steps to address it.

All staff are responsible for:

- raising concerns where they believe that patient safety or care is being compromised (see also the Trust's Policy on '*Freedom to Speak Up: Raising Concerns Policy)*
- reporting concerns about a doctor's conduct or capability
- attending any meetings as requested by an investigating officer and participating fully in an investigation process
- giving a full account of the circumstances of any case during an investigation and disciplinary or capability hearing
- Attending and engaging in disciplinary and capability hearing and any appeal in accordance with policy and process

4.11 HUMAN RESOURCES

The Human Resources Department will:

- Provide advice to both staff and managers at any stage in the procedure
- Be responsible for monitoring and advising to ensure that disciplinary decisions are consistent and fair
- Review the policy in light of changes

5 PROCEDURE

5.1 INITIAL PROCEDURE

5.1.1 As a general principle, it is expected that the immediate clinical line manager of the practitioner will deal with issues of minor misconduct or performance (if necessary with HR support) without resort to the Medical Director (MD). In such circumstances, it may or may not be appropriate for the MD to be informed of the outcome. If a Line Manager is in any doubt, they should err on the side of caution and report it to the Medical Director.

5.1.2 Unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore, all allegations, including those made by patients and relatives, and concerns raised by colleagues, must first be investigated to verify the facts, and careful judgement is required to follow these processes.

5.1.3 **FACT FINDING PROCESS**

The aim of this process is to gather enough information to identify the nature of the concern, whether it has any substance, and to help inform and rationalise whether the issue can be dealt with informally or needs to be addressed via the formal procedure.

This process will normally involve the Line Manager establishing the immediate facts surrounding the complaint/concern. This should start with a first-hand account from the practitioner, who should be fully informed of the concern before being asked to comment. This process can include any documentary records such as timesheets, written statements from the member of staff who raised the concern and any other witnesses. At this stage all readily available information should be sourced and considered.

This will not involve inviting individuals to formal meetings as this would be part of any subsequent investigation process if required.

The individual whom the complaint is the subject must be informed and advised that a complaint/concern has been received and that a fact finding process to establish the immediate facts surrounding the case is being undertaken. There are only a very few circumstances where this might not be appropriate, for example where a concern involves potential fraud or criminal investigation, or where it is immediately apparent that there is no case to answer.

The individual should be assured that the process is to establish the facts that no formal process has been entered into, that they will be kept informed and the matter will be progressed as quickly as is reasonably practicable.

It is important that the line manager engage with and support the practitioner.

Key principles of the fact finding process:

- Line Manager gathers readily available facts/ information that has given rise to the concern
- The Line Manager should not automatically attribute an incident to the actions or failings of an individual. A Human Factors approach should be used to explore whether there are staffing, training or resource issues that have contributed to the incident
- Information is gathered surrounding the concern and complaint
- The individual concerned must be informed of the investigation and outcome of the fact-finding process
- Process managed locally with HR support
- Feedback must be given to the person who reported the issue

It is expected that a fact finding process would be completed within 28 days

5.1.4 Following completion of the fact finding the line manager will decide that:

a) there is no case to answer and no further action required,

b) the matter can be dealt with informally. This may include remedial supportive action, further training or modification of responsibilities, job plan review, and referral to the Occupational Health department or issuing a formal letter by the Medical Director. The appropriate formal procedure will be followed if the practitioner does not agree to the MD's proposals in this regard.

The matter may be managed in line with the Remediation and Support for Medical Staff Policy to ensure there is support in place for any practitioner that may be in difficulty.

c) the matter may constitute a serious concern and needs referral to the MD

5.1.5 On conclusion of the fact finding process, the practitioner should be informed in writing of the outcome, with a copy being recorded on the personal file.

5.1.6 Where a vexatious grievance is found to have been brought, the person who brought that grievance may find the disciplinary procedure is put into action for them as a result. This may be where a complaint is unreasonable or the employer considers this to be a vexatious grievance.

5.1.7 If the situation can be resolved informally it is also important for the line manger to consider that the behaviours that led to the concern being raised, even if apparently minor concerns may be signs that a colleague has underlying personal or professional difficulties. These should be explored as part of this process to see if

additional support or reasonable adjustments can be made to help rectify the situation.

5.1.8 Follow up: the line manager should arrange to meet the individual concerned informally after a suitable time frame to assess progress and make sure the individual is appropriately supported.

5.1.9 If a concern is dealt with informally this should be recorded on the practitioner's personal file, as should any meetings following a review period identified in 5.1.8.

5.1.10 Allegations or issues of concern, which are not resolved by the immediate clinical line manager, will be referred to the Medical Director.

5.1.11 At this stage the Medical Director will either:

a) Decide that the matter can be resolved by the Line Manager or through informal resolution by the Medical Director.

b) Decide that the matter is so serious that it needs to proceed immediately under the full MHPS investigatory process (set out below in Section 5)

c) Refer the issue to the Medical Concerns Decision Making Group for consideration after which the MD will decide the best course of action in line with paragraphs above.

5.1.12 **GOOD DOCUMENTATION**

Good documentation is a necessary component of any process, a secure record of all documentation arising from processes described in this document will be kept when responding to concerns. Such records should be shared with the practitioner as early as possible unless there are legal or statutory reasons not to, and it is good practice to invite the doctor to contribute appropriately to their content and to have any dispute about the content recorded.

A practitioner may request access to all documentation, which will be shared with them unless there are legal or statutory reasons not to. The practitioner has the right to see all information relating to the case and a list of the people that the investigator will interview as well as a copy of any statements taken. This should be received by the practitioner within 20 working days of any request, and in good time ahead of any investigation meeting.

When accessing advice and guidance from the PPA it will be expected that the practitioner has been advised regarding the concerns held, that contact with the PPA has been made and the outcome of that advice will be shared with the practitioner, except for very limited circumstances where this would compromise the investigation of the case (for example, where there is alleged fraud or criminal activity). The PPA works with the Trust to ensure that concerns raised about an individual practitioner are managed and resolved in a fair, proportionate and timely way. The practitioner must be kept informed and decisions taken must take into account the welfare of the practitioner.

5.2 ACTION WHEN A SERIOUS CONCERN ARISES

5.2.1 INTRODUCTION

All serious concerns must be registered with the Chief Executive and they must ensure that a case manager is appointed. The Chair of the Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director will need to work with Human Resources to decide the appropriate course of action in each case. The Medical Director will act as the case manager or may delegate this role to a senior clinician or senior manager in conduct cases, to oversee the case on his or her behalf. The Medical Director, in conjunction with the case manager as appropriate, is responsible for ensuring the appointment of a case investigator.

Safeguarding

Where a case involves allegations of abuse by NHS staff that indicate that young children, young people, or adults at risk are believed to have suffered, or are likely to suffer, significant harm the Managing Safeguarding Allegations Against Staff Policy and Procedure should be referred to for more detailed guidance. A Framework for Managing Safeguarding Allegations is provided in the Trust's Managing Allegations against Staff Policy Managing Allegations Against Staff

Counter Fraud

In any cases where fraud (as defined by the Fraud Act 2006 or Theft Act 1968) is suspected, the matter should be reported to the Trust's Local Counter Fraud Specialist immediately. Further information can be obtained from the Trust's Counter Fraud Statement Counter Fraud And-Bribery Statement.

Just Culture (Appendix 7)

The Just Culture approach supports consistent, constructive, and fair evaluation of the actions of staff involved in patient safety incidents. All practitioners are fallible, and mistakes and errors will be made. The Just Culture Approach (Appendix 7) provides a clear framework to assess whether a patient safety incident requires specific individual investigation and support or identifies an organisational issue that requires wider actions. This approach protects staff and patients by ensuring that wider patient safety issues are addressed as an organisation, rather than as individual issues.

The Just Culture Guide can be used at any point of the investigation and may need to be revisited if more information becomes available.

5.2.2 EXCLUSION

The duty to protect patients is paramount. When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Sections 5.2.9 – 5.2.22 of this document sets out the procedures for this action.

The Risk Assessment Exclusion tool in Appendix 2 must be used prior to any action being taken about whether to immediately exclude/redeploy/restrict/amend the duties of any staff members.

At any point in the process where the case manager has reached the clear judgement that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner should be discussed with the GMC/GDC, whether or not the case has been referred to PPA.

Consideration should also be given to whether the issue of an alert letter should be requested.

5.2.3 IDENTIFYING THERE IS A PROBLEM

The first task of the Medical Director/Case Manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with the Medical Concerns Decision Making Group, Human Resources and PPA as appropriate.

PPA can provide a sounding board for the case manager's initial thoughts. However, PPA asks that the first approach to them should be made by the Trust's Chief Executive or Medical Director. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean should be involved as soon as possible.

The Medical Director/case manager should explore the potential problem with PPA to consider different ways of tackling it themselves, possibly recognising the problem as being more to do with work systems than doctor performance or see a wider problem needing the involvement of an outside body other than PPA.

The Medical Director/case manager should not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of adverse events should be conducted as these frequently show that causes are more broadly based and can be attributed to systems or organisational failures or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions. NHSI facilitates the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses and the case manager should consider contacting NHSI for advice about systems or organisational failures.

Having discussed the case with PPA and/or NHSI, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen PPA should still be involved until the problem is resolved. This can include PPA undertaking a formal clinical performance assessment when the doctor, the NHS body and PPA agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps. If PPA is asked to undertake an assessment of the doctor's practice, the outcome of a local investigation may be made available to inform its work.

When accessing advice and guidance from the PPA and or NHSI, it is expected that the practitioner will be advised regarding the nature of the concerns and the contact made. The

outcome of that advice will be shared with the practitioner, except for very limited circumstances where this would compromise the investigation of the case (for example, where there is alleged fraud or criminal activity).

Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Chief People Officer, appoint an appropriately experienced or trained person as case investigator and case manager (if not the MD). The seniority of the case investigator will differ depending on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained to enable them to carry out this role when required.

5.2.4 **THE INVESTIGATION**

The practitioner concerned must be informed in writing by the Medical Director/case manager, as soon as it has been decided that an investigation is to be undertaken, the name of the case investigator and made aware of the specific allegations or concerns that have been raised. The practitioner should be sent the terms of reference for the investigation (Appendix 6). The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the case investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied. If the practitioner fails to engage in the process the investigation will be finalised without their input.

At any stage of this process – or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body, an official or representative of the British Medical Association (or any other recognised trade union), British Dental Association or a defence organisation, or work colleague, a friend, partner, or spouse. The companion may be legally qualified but they will not be acting in a legal capacity.

The case investigator has discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner and report the findings. Investigations are not intended simply to secure evidence against the practitioner as information gathered during an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter.

If, during the investigation, it transpires that the case involves more complex clinical issues than first anticipated, the case manager should arrange for a practitioner in the same speciality and of the same grade from another NHS body to assist.

The case investigator should aim to complete the investigation within four weeks of appointment and submit their report to the case manager within a further five working days. All best endeavours will be used to complete the investigation within four weeks but, if this is not possible, an interim report will be made after the four weeks. The report of the investigation should give the case manager sufficient information to make a decision as to whether:

- no further action is needed
- to exercise the Medical Director’s discretion to make proposals for resolving the matter as an alternative to the actions below

- there is a case of misconduct that should be put to a conduct panel (disciplinary hearing) via the implementation of the relevant HR policies and procedures e.g. Trust Disciplinary Policy. The Medical Director in consultation with the Chief People Officer or nominated deputy, will establish which of these Trust procedures will be appropriate in accordance with the principles of the MHPS Policy
- there are concerns about the practitioner's health that should be considered by the Occupational Health department and, if necessary, dealt with via implementation of the Trust's Supporting Attendance Policy or Alcohol and Substance Misuse Policies
- there are concerns about the practitioner's performance that should be further explored by PPA
- restrictions on practice or exclusion from work should be considered (see Sections 5.2.9 – 5.2.22 and Appendix 2)
- there are serious concerns that should be discussed with the GMC or GDC
- there are intractable problems, and the matter should be put before a capability panel (Section 5.4).

5.2.5 INVOLVEMENT OF PPA FOLLOWING LOCAL INVESTIGATION

Medical under-performance can be due to health problems, difficulties in the work environment, behaviour, or a lack of clinical capability. These may occur in isolation or in a combination. PPAs' processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. PPAs' methods of working therefore assume commitment by all parties to take part constructively in a referral to PPA. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.

The focus of PPAs' work is therefore likely to involve performance difficulties which are serious and/or repetitive. This means:

- performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk

- alternatively, or additionally, problems that are on-going or (depending on severity) have been encountered on at least two occasions.

In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process. PPA may advise on this.

Where the Trust is considering excluding a doctor or dentist (whether their performance is under discussion with PPA), the Trust will inform PPA of this at an early stage so that alternatives to exclusion are considered. Procedures for exclusion are covered in Sections 5.2.9 – 5.2.22 of the procedure. It is particularly desirable to find an alternative when PPA is likely to be involved because it is much more difficult to assess a practitioner who is excluded from practice than one who is working.

A practitioner undergoing assessment by PPA must co-operate with any request to give an undertaking not to practice in the NHS or private sector, other than their main place of NHS employment, until the PPA assessment is complete. (Under circular HSC 2002/011, Annex 1, paragraph 3, "A doctor undergoing assessment by PPA must give a binding undertaking

not to practice in the NHS or private sector other than in their main place of NHS employment until the assessment process is complete").

Failure to co-operate with a referral to PPA may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the Trust on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the parties and may necessitate disciplinary action and consideration of referral to the GMC or GDC.

5.2.6 CONFIDENTIALITY

In discharging its duty of care to its staff the Trust will maintain confidentiality. The information provided externally (e.g. to the media) will be restricted only to confirming that an investigation or disciplinary hearing is underway. The Trust will not release the name of the practitioner or issue a press notice at this stage.

Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose and not disproportionate to the seriousness of the matter under investigation. The Trust will operate consistently with the guiding principles of the *Data Protection Act 2018* (enacting the *General Data Protection Regulations*).

5.2.7 STAFF SUPPORT

The Trust recognises that, irrespective of the outcome, practitioners involved in this process are likely to find the experience traumatic and stressful. Support is available, at any stage of the procedure, from the Staff Health and Wellbeing department, the Trust's Employee Assistance Programme and the practitioner's trade union or professional body.

5.2.8 OVERLAPPING EMPLOMENT RELATIONS PROCESSES (DISCPLINARY, GRIEVANCE, CAPABILITY)

Where a staff member raises a grievance during a capability/disciplinary process, the process may be temporarily suspended in order to deal with the grievance. However, each case will be considered on its own merits and any potential delay must be risk assessed for its impact on patient and/or staff safety using an Impact Assessment form (see Appendix 3). It may be appropriate to deal with both issues concurrently.

5.2.9 RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK

Please note: the phrase *exclusion from work* has been used instead of the word *suspension* which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

The Risk Assessment Exclusion tool at Appendix 2 must be used prior to any action being taken about whether to exclude/redeploy/restrict/amend the duties of any staff members.

The Trust will ensure that:

- exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered
- where a practitioner is excluded, it is for the minimum necessary period of time. This can be up to, but no more than, four weeks at a time (see paragraph 5.3.3. and 5.3.5. for details re immediate exclusion)
- all extensions of exclusion are reviewed, and a brief report provided to the Chief Executive and Board
- a detailed report is provided, when requested, to the "Designated Board Member" who will be responsible for monitoring the situation until the exclusion has been lifted.

5.2.10 **MANAGING THE RISK TO PATIENTS**

Where serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings, or provide for the exclusion of a practitioner from the workplace. Exclusion will be considered as a last resort if alternative courses of action are not feasible. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean should be involved as soon as possible.

Exclusion of clinical staff from the workplace is a temporary expedient. It is a precautionary measure and not a disciplinary sanction. Exclusion from work will be reserved for only the most exceptional circumstances.

The purpose of exclusion is:

- to protect the interests of patients or other staff and/or
- to assist the investigative process when there is a clear risk that the practitioner's presence would impede or otherwise compromise or contaminate the gathering of evidence

It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

Alternative ways to manage risks, avoiding exclusion, include:

- medical or clinical director supervision of normal contractual clinical duties
- restricting the practitioner to certain forms of clinical duties
- restricting activities to administrative, research/audit, teaching, and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling
- sick leave for the investigation of specific health problems.

In cases relating to the capability of a practitioner, consideration will be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach will be sought from the PPA. If the nature of the problem and a workable remedy cannot be determined in this way, the case manager will seek to agree with the practitioner to refer the case to PPA which can assess the problem in more depth

and give advice on any action necessary. The case manager will seek telephone advice from PPA when considering restriction of practice or exclusion.

5.2.11 **THE EXCLUSION PROCESS**

The risk assessment Exclusion tool (Appendix 2) must be used prior to any action taken about whether to exclude/redeploy/restrict/amend the duties of any practitioner.

Key features of exclusion from work:

- an initial *immediate* exclusion of no more than two weeks if warranted
- notification to PPA before formal exclusion
- formal exclusion (if necessary) for periods up to four weeks
- advice on the case management plan from PPA
- appointment of a Board member to monitor the exclusion and subsequent action
- referral to PPA for formal assessment if part of a case management plan
- active review to decide renewal or cessation of exclusion
- a right to return to work if review not carried out
- performance reporting on the management of the case
- programme for return to work if not referred to disciplinary procedures or performance assessment.

The Trust will not exclude a practitioner for more than four weeks at a time without a review (see Section 5.2.13 for details of immediate exclusion). The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Key officers and the Trust Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

5.2.12 **THE ROLES OF THE OFFICERS**

The Trust Chief Executive has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by the following:

- Chief Executive Officer or his/her deputy
- Medical Director or his/her deputy
- Chief People Officer and his/her deputy

The case will be discussed fully with the Chief Executive, the Medical Director, Human Resources, The Medical Concerns Decision Making group MDAG, PPA and other interested parties (such as the police where there are serious criminal allegations, the Counter Fraud & Security Management Service or Safeguarding Children or Adults representatives) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

The Medical Director will act as the case manager in the case of consultant staff, or delegate this role to a senior medical manager to oversee the case, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member. The investigating officer will provide factual information to assist the case manager

in reviewing the need for exclusion and making progress reports to the Chief Executive and Designated Board member.

5.2.13 **IMMEDIATE EXCLUSION**

In exceptional circumstances an immediate time-limited exclusion may be necessary, following:

- a critical incident when serious allegations have been made, or
- where there has been a significant breakdown in relationships between a colleague and the rest of the team, or
- where the presence of the practitioner is likely to hinder the investigation
- where the presence of the practitioner may give rise to the risk of destruction or contamination of evidence or interference with witnesses**.**

Such exclusion will allow a more measured consideration to be undertaken and the PPA should be contacted before the immediate exclusion takes place. This period should be used to carry out a preliminary situation analysis, to seek further advice from PPA and to convene a case conference.

The practitioner must be advised as to why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date, up to a maximum of two weeks away, when the practitioner should return to the workplace for a further meeting.

The case manager must advise the practitioner of their rights, including rights of representation.

5.2.14 **Formal Exclusion**

A formal exclusion may only take place after the case manager has first considered whether there is a potential case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. PPA must be consulted where formal exclusion is being considered. This should be informed by the fact finding report and completion of the risk assessment exclusion tool at Appendix 2.

The fact finding report should provide sufficient information for a decision to be made as to whether:

- the allegation appears unfounded, or
- there is a potential misconduct issue, or
- there is a concern about the practitioner's capability, or
- the complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be enquired into.

Formal exclusion of one or more clinicians must only be used where:

- there is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:
    - allegations of misconduct
    - concerns about serious dysfunctions in the operation of a clinical service

- concerns about lack of capability or poor performance of sufficient seriousness that is warranted to protect patients,

- the presence of the practitioner(s) in the workplace is likely to hinder the investigation.

Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

When the practitioner is informed of the exclusion, there should be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to Occupational Health, referral to PPA with voluntary restriction).

The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state:

- the effective date and time
- duration (the initial exclusion a maximum of two weeks and then up to four weeks thereafter)
- the content of the allegations
- the terms of the exclusion
- the need to remain available for work and
- that a full investigation will be undertaken or what other action will follow.

The practitioner should also be advised that they may make representations about the exclusion to the Designated Board member at any time after receipt of the letter confirming the exclusion.

In cases when disciplinary procedures are being followed, exclusion may be extended for four-week renewable periods until the completion of disciplinary procedures if a return to work is considered inappropriate.

The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, as soon as the original reasons for exclusion no longer apply.

If the case manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example, because of a police investigation), the case must be referred to PPA for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period, the principle of four-week "renewability" must be adhered to.

If, at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

5.2.15 **EXCLUSION FROM THE PREMISES**

Practitioners will not be automatically barred from the premises upon exclusion from work. The case manager must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence or where the practitioner may be a serious potential danger to patients or other staff. In other circumstances, however, there may be no reason to exclude the practitioner from the premises.

Where a practitioner is barred from the premises, the Medical Director will decide whether this exclusion extends to remote access to the hospital IT network, or whether specific exclusions should be applied (e.g. a requirement not to contact or email witnesses).

Exclusion from premises and the IT network should only be used in exceptional circumstances. They must be clearly justified, with arrangements to ensure the excluded practitioner can access any resources needed to help in their defence.

5.2.16 **KEEPING IN CONTACT AND AVAILABILTY FOR WORK**

The practitioner should normally be allowed to retain contact with colleagues, take part in clinical audit and remain up to date with developments in their field of practice or undertake research or training.

Exclusion under this procedure will be on full pay therefore the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continue undertaking such work or to take annual leave or study leave.

The practitioner should be reminded of these contractual obligations but should be given 24 hours' notice to return to work. In exceptional circumstances the case manager may decide that payment is not justified because the practitioner is no longer available for work (e.g.: abroad without agreement).

The case manager should make arrangements to ensure that the practitioner can keep in contact with colleagues on professional developments and take part in Continuing Professional Development (CPD) and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

5.2.17 **INFORMING OTHER ORGANISATIONS**

In cases where there is concern that the practitioner may be a danger to patients, the Trust may consider that it has an obligation to inform such other organisations, including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) should be readily available from job plans but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body as the paramount interest is the safety of patients. Where an NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

Where the case manager believes that the practitioner is practising in other parts of the NHS or in the private sector in breach of an undertaking not to do so, they should contact the professional regulatory body and the Director of Public Health or Medical Director of NHS Improvement to consider the issue of an alert letter.

5.2.18 SUPPORT FOR THE PRACTITIONER

It is recognised that exclusion can be a stressful experience and a nominated person will maintain regular contact with the excluded member of staff to monitor their wellbeing and provide them with relevant information. The Trust also has additional support mechanisms in place:

Managers may refer the practitioner to Staff Health and Wellbeing

The practitioner may contact the free, confidential 24 hour staff support line provided by the Trust's Employee Assistance Programme.

The staff member may also contact the Freedom to Speak Up Guardian at any point during their exclusion

The practitioner may seek support and advice from their trade union or professional defence organisation

The practitioner may contact Non-Executive Director if they have significant concerns about the progress of the investigation or any exclusion from work.

5.2.19 INFORMAL EXCLUSION

No practitioner will be excluded from work other than through this procedure. The Trust will not use *garden leave* or other informal arrangements as a means of resolving a problem covered by this procedure.

5.2.20 KEEPING EXCLUSIONS UNDER REVIEW

INFORMING THE BOARD

The Board must be informed about any exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. Therefore:

- a summary of the progress of each case at the end of each period of exclusion will be provided to the Non-executive Director and Chief Executive, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible.

- a quarterly statistical summary, showing all exclusions with their duration and number of times the exclusion has been reviewed and extended, will be provided with a copy sent to NHS Improvement.

REGULAR REVIEW

The case manager must review the exclusion before the end of each four-week period and report the outcome to the Chief Executive and the Board. This report is advisory and it would be for the case manager to decide on the next steps as appropriate.

The exclusion should usually be lifted, and the practitioner allowed back to work, with or without conditions placed upon his/her employment, at any time if the original reason(s) for exclusion no longer apply and there are no other reasons for exclusion.

The exclusion will lapse, and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and consider the option of the practitioner returning to limited or alternative duties where practicable.

The Trust must take review action before the end of each four-week period. After three exclusions, PPA must be called in. The information below outlines the activities that must be undertaken at different stages of exclusion.

The Trust will use the same timeframes to review any restrictions upon practice that have been placed on a practitioner, although the requirements for reporting to the Board and NHS Improvement do not apply in these circumstances.

It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal hearing. Therefore, information to the Board should only be sufficient to enable them to confirm that the procedures are being followed. Only the Designated Board Member should be involved to any significant degree in each review.

FIRST AND SECOND REVIEWS (AND REVIEWS AFTER THE THIRD REVIEW)

Before the end of each exclusion period (of up to four weeks) the Case Manager must review the position.

- The case manager decides on next steps as appropriate, considering the views of the practitioner. Further renewal may be for up to four weeks.

- The case manager submits an advisory report of outcome to the Chief Executive and Trust Board.

- Each renewal is a formal matter and must be documented as such.

- The practitioner must be sent written notification on each occasion.

THIRD REVIEW

If the practitioner has been excluded for three periods:

- a report must be made to the Chief Executive outlining the reasons for the continued exclusion, why restrictions on practice would not be an appropriate alternative and, if the investigation has not been completed, a timetable for completion of the investigation

- the Chief Executive must report to NHS Improvement and the Designated Board Member

- the case must formally be referred to PPA explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion at the earliest opportunity

SIX-MONTH REVIEW

If the exclusion has been extended over six months:

- a further position report must be made by the Chief Executive to NHS Improvement indicating the reason for continuing the exclusion, the anticipated time scale for completing the process and the actual and anticipated costs of exclusion

- PPA and/or NHS Improvement will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can offer to the Board.

There will be a normal maximum limit of six months' exclusion except for those cases involving criminal investigation of the practitioner concerned. The Trust and PPA will actively review such cases at least every six months.

5.2.21 THE ROLE OF THE BOARD AND DESIGNATED MEMBER

The Board is responsible for designating one of its non-executive members as a Designated Board member under these procedures. The Designated Board member is the person who oversees the case manager and case investigator during the investigation process and maintains momentum of the process.

The member's responsibilities include:

- receiving reports and reviewing the continued exclusion from work
- considering representations from the practitioner about their exclusion
- considering any representations about the investigation.

Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the Designated Board member should be involved to any significant degree in each review.

5.2.22 RETURN TO WORK

If it is decided that the exclusion should come to an end, there must be formal arrangements for the practitioner's return to work. It must be clear whether clinical and other responsibilities are to remain unchanged or what the duties and restrictions are to be, and any monitoring arrangements to ensure patient safety.

5.3 CONDUCT AND DISCIPLINARY MATTERS

Cases which solely involve allegations of misconduct against medical or dental staff will be dealt with, as for all other staff groups, under the Trust's Disciplinary Policy (a copy of which

is available on the Trust's Hub) but only after the procedure for investigating allegations of misconduct referred to in this policy have been undertaken. However, where any concerns about the conduct of a medical or dental practitioner are raised, the Trust will contact the Practitioner Performance Advice (PPA) for advice before proceeding.

Where the alleged misconduct being investigated under the Trust's Disciplinary Policy relates to matters of a professional nature or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice.

When a report of the conduct investigation has been received, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments.

Similarly, where a case involving issues of professional conduct proceeds to a hearing under the Trust's Disciplinary Policy and Procedure, the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.

The Trust will work with the relevant university or NHS organisation to ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts.

The Trust's Disciplinary Policy sets out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct".

These will generally fall into four distinct categories:

- a refusal to comply with reasonable requirements of the Trust including values, Behaviour Standards and non-medical staff policies
- an infringement of the Trust's disciplinary rules including conduct that contravenes the standard of professional behaviour required of doctors and dentists by their regulatory body
- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care, patient safety or create serious dysfunction to the effective running of a service.

Examples of issues that should be investigated under the Capability Procedure are set out in paragraph 5.4.

Any allegation of misconduct against a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the Postgraduate Dean from the outset.

Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities, may come into this category. Additionally, instances of failing to give proper support to other

members of staff, including doctors or dentists in training, may be considered in this category.

The Trust, having consulted PPA and the Chief People Officer or nominated deputy will decide upon the most appropriate way forward.

If a practitioner considers that the case has been wrongly classified as misconduct, they (or their representative) are entitled to use the Trust's Grievance Policy. Alternatively, or in addition, they may make representations to the Designated Board member.

5.3.1 ACTION WHEN INVESTIGATIONS IDENTIFY POSSIBLE CRIMINAL ACTS

Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The Trust will consult the police to establish whether an investigation into any other matters would impede their investigation.

In any case where fraud is suspected, the matter shall be reported to the Trust's Local Counter Fraud Specialist immediately.

It is important that any investigation conducted by the Trust does not interfere with any evidence that may be used to resolve any suspicion of criminal wrongdoing. Equally, the Trust recognises that investigations conducted by any law enforcement body are outside of the control of the Trust and operate under their processes, which may differ from those of the Trust. This may mean that parallel investigations run concurrently. There is no set order in which aspects of each investigation should occur; they should be decided on a case-by-case basis between the investigators involved.

5.3.2 CASES WHERE CRIMINAL CHARGES ARE BROUGHT NOT CONNECTED WITH AN INVESTIGATION BY THE TRUST

There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, the Trust, having considered the facts, will need to consider whether the practitioner poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner.

The Trust will have to give serious consideration to whether the practitioner can continue in their job once criminal charges have been made. Bearing in mind the presumption of innocence, the Trust will consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the practitioner can continue in their present job, should be allocated to other duties, or should be excluded from work. This will depend on the nature of the offence and advice will be sought from the Medical Director, Chief People Officer and/or the Trust's legal adviser. The Trust will explain the reasons for taking such action to the practitioner concerned.

5.3.3 DROPPING OF CHARGES OR NO COURT CONVICTION

When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but the Trust feels there is enough evidence to suggest a potential danger to patients, and then the Trust has a public duty to take action to ensure that the individual concerned does not pose a risk to patient safety.

Similarly, where there are insufficient grounds for bringing charges, or the court case is withdrawn, there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned.

Where charges are dropped, the presumption is that the practitioner will be reinstated.

5.3.4 TERMS OF SETTLEMENT ON TERMINATION OF EMPLOYMENT

In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following principles will be used by the Trust in such circumstances.

Settlement agreements must not be to the detriment of patient safety.

It is not acceptable to agree any settlement that precludes either appropriate investigations being carried out and reports made or referral to the appropriate regulatory body.

Payment will not normally be made when a practitioner's employment is terminated on disciplinary grounds or following their resignation.

Expenditure on termination payments must represent value for money. The Trust would need to demonstrate why the severance payment is in the public interest, how it represents value for money and how it represents the best use of public funds. The matter would need to be considered and agreed by the Trust's Remuneration Committee and NHS Improvement prior to submission to HM Treasury for approval. A clear record must be kept, setting out the calculations, assumptions and rationale of all decisions taken to show that the Trust or authority has taken into account all relevant factors including legal advice.

Offers of compensation, as an inducement to secure the voluntary resignation of an individual, must not be used as an alternative to the disciplinary process.

All job references must be accurate, realistic, and comprehensive and, under no circumstance, may they be misleading.

Where a termination settlement is agreed, details may be confirmed in a Settlement Agreement that should set out what each party may say in public or write about the settlement. The Settlement Agreement is for the protection of each party. It should comply with NHS Employers' guidance on the use of such agreements and must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an *open reference*. For the purposes of this paragraph, an *open reference* is one that is prepared in advance of a request by a prospective employer.

5.4 PROCEDURE FOR DEALING WITH ISSUES OF CAPABILITY

There will be occasions where the Trust considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability, or consistently poor performance. These are described as *capability issues*. Matters that should be described and dealt with as misconduct issues are covered in Section 5.3 of this procedure.

Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports, or poor clinical outcomes. Advice from PPA will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties, or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, the matter must be referred to PPA before the matter can be considered by a capability hearing.

No member of the capability panel or advisers to the panel should have been previously involved in carrying out an investigation.

Matters which fall under the Trust's capability procedures include:

- out of date clinical practice
- inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk
- incompetent clinical practice
- inability to communicate effectively with colleagues and/or patients
- inappropriate delegation of clinical responsibility
- inadequate supervision of delegated clinical tasks
- ineffective clinical team working skills.

This is not an exhaustive list.

Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through on-going assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. PPA will be consulted for advice to support the remediation of a doctor or dentist.

5.4.1 HOW TO PROCEED WHERE CONDUCT AND CAPABILITY ISSUES ARE INVOLVED

It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. The decision as to which process should be initiated shall be taken by the Medical Director/case manager in conjunction with the Chief People Office or their deputy and PPA.

The practitioner is also entitled to use the Trust's grievance procedure if they consider that the case has been incorrectly classified. Alternatively, or in addition, they may make representations to the Designated Board member.

5.4.2 DUTIES OF EMPLOYERS

The procedures set out below are designed to cover issues where a doctor's or dentist's capability to practice is in question. Prior to instigating these procedures, the Trust will consider the scope for resolving the issue through counselling or retraining and will take advice from PPA.

Capability may be affected by ill-health, and this will be considered in any investigation. Arrangements for handling concerns about a practitioner's health are described in section 5.5 of this procedure.

The Trust will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of age, disability, gender/gender identity/gender re-assignment, marital status/civil partnership, maternity/pregnancy, race, religion/belief or sexual orientation.

The Trust will ensure that managers and case investigators receive appropriate and effective training in the operation of this procedure. Those undertaking investigations or sitting on capability or appeal hearings must have had formal equality and inclusion training before undertaking such duties. The Trust Board will agree on what training staff and Board members must have completed before they can take part in these proceedings.

5.4.3 CONSIDERATION BY CASE MANAGER

When a report of the capability investigation has been received the case manager they must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator.

Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of receipt of the request for comments. In exceptional circumstances, for example, in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

The case manager should decide what further action is necessary, considering the report's findings, any comments that the practitioner has made and the advice of PPA.

The case manager will need to consider urgently whether:

- action under Section 5.2 of the procedure is necessary to exclude the practitioner, or
- to place temporary restrictions on their clinical duties

The case manager will also need to consider, with the Medical Director and Chief People Officer or their deputy whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to PPA for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The case manager will inform the practitioner concerned of the decision as soon as possible and normally within 10 working days of receiving the practitioner's comments.

PPA will assist the Trust in drawing up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by PPA but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by PPA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

If the practitioner does not agree to the case being referred to PPA, a panel hearing will normally be necessary.

If a capability hearing is to be held, the following procedure will be followed beforehand:

The case manager must notify the practitioner in writing of the decision to arrange a capability hearing at least 20 working days in advance. Notification must include details of the allegations and the arrangements for proceeding, including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so choose.

All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the Trust will consider whether a new date should be set for the hearing.

Should either party request a postponement to the hearing, the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not less than 30 working days), to proceed with the hearing in the practitioner's absence although the Trust will act reasonably in deciding to do so, considering any comments made by the practitioner.

Should the practitioner's ill health prevent the hearing from taking place, the Trust will implement its usual absence procedures and involve the Occupational Health department as necessary.

Witnesses who have made written statements at the inquiry stage may will not necessarily be required to attend the capability hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chair will invite the witness to attend. The Chair cannot require anyone other than a staff member to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel will reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.

If witnesses who are required to attend the hearing choose to be accompanied, the accompanying person cannot participate in the hearing.

5.4.4 **THE HEARING FRAMEWORK**

The capability hearing will be chaired by an Executive Director of the Trust. The panel will comprise a total of 3 people, normally 2 members of the Trust Board or senior staff, appointed by the Board for the purpose of the hearing. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust. The Trust will agree the external medical or dental member with the Chair of the Joint Local Negotiating Committee (JLNC)

Arrangements must be made for the panel to be advised by:

- a senior member of staff from Human Resources, and
- a senior clinician from the same or similar clinical specialty as the practitioner concerned but from another NHS employer.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

It is for the Trust to ultimately decide upon the membership of the panel. The practitioner may raise an objection to the choice of any panel member within five working days of notification. The Trust will review the situation and will respond in writing prior to the hearing stating the reasons for the decision. The Trust will take all reasonable measures to ensure that the membership of the panel is acceptable to the practitioner and, exceptionally, it may be necessary to postpone the hearing while this matter is resolved.

5.4.5 REPRESENTATION AT CAPABILITY HEARINGS

The practitioner will be given every reasonable opportunity to present their case although the hearing should not be conducted in a legalistic or excessively formal manner.

Practitioners have the right to be represented and/or accompanied by a companion who may be another employee of the NHS body, an official or representative of the British Medical Association [or any other recognised trade union], British Dental Association or a defence organisation, or work colleague, a friend, partner, or spouse. The companion may be legally qualified but they will not be acting in a legal capacity.

The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

5.4.6 CONDUCT OF THE CAPABILITY HEARING

The hearing should be conducted as follows:

- The Chair of the panel will be responsible for the proper conduct of the proceedings.

- The Chair should introduce all persons present and announce which witnesses are available to attend the hearing the panel and its advisers, the practitioner, their representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire.

- The procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:
    - the side calling the witness can question the witness
    - the other side can then question the witness
    - the panel may question the witness
    - the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence

The order of presentation shall be:

- the case manager presents the management case including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave

- the Chair shall invite the case manager to clarify any matters arising from the management case on which the panel requires further clarification

- the practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.

- the Chair shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification

- the Chair shall invite the case manager to make a brief closing statement summarising the key points of the case

- the Chair shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation

- the panel shall then retire to consider its decision.

5.4.7 **DECISIONS**

The panel will have the power to make a range of decisions including the following:

- no action required

- oral agreement that there must be an improvement in clinical performance within a specified time-scale with a written statement of what is required and how it might be achieved [stays on the practitioner's record for six months]

- written warning that there must be an improvement in clinical performance within a specified time-scale with a statement of what is required and how it might be achieved [stays on the practitioner's record for one year]

- final written warning that there must be an improvement in clinical performance within a specified time-scale with a statement of what is required and how it might be achieved [stays on the practitioner's record for one year]

- termination of contract.

It is also reasonable for the panel to make comments and recommendations on issues, other than the competence of the practitioner, where these issues are relevant to the case. For

example, there may be matters around the systems and procedures operated by the Trust that the panel wishes to comment upon.

A record of verbal agreements and written warnings should be kept on the practitioner's personnel file with the duration of any warning explicitly documented.

Because of the complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing. Where this is impractical, the panel has the discretion to make alternative arrangements. However, the panel's decision will be communicated to both parties as soon as possible and normally within five working days of the hearing.

The decision must be confirmed in writing to the practitioner. This notification must include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

5.4.8 APPEAL IN CAPABILITY CASES

The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel, in arriving at their decision, acted fairly and reasonably based on:

- a fair and thorough investigation of the issue
- sufficient evidence arising from the investigation or assessment on which to base the decision
- whether, in the circumstances, the decision was fair and reasonable and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not rehear the case in its entirety (but in certain circumstances it may order a new hearing.

A dismissed practitioner can potentially take their case to an Employment Tribunal where the reasonableness of the Trust's actions can be tested.

5.4.9 THE CAPABILITY APPEAL PROCESS

The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the capability hearing or order that the case is reheard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chair of the panel shall have the power to instruct a new capability hearing.

Where the appeal is against dismissal, the practitioner should not be paid during the appeal if it is heard after the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to rehear the case, the practitioner should also be

reinstated, subject to any conditions or restrictions in place at the time of the original hearing and pay backdated to the date of termination of employment.

5.4.10 **THE CAPABILITY APPEAL PANEL**

The panel will consist of three members. The members of appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the Designated Board member. These members will be:

- an independent member (trained in legal aspects of appeals) from an approved pool. This person will be appointed from the national list held by NHS Employers for this purpose. This person will act as Chair

- the Trust's Chair (or other non-executive director of the Trust) who must have the Appropriate training for hearing an appeal

- a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust who must also have the appropriate training for hearing an appeal. The Trust will agree the external medical or dental member with the Chair of the JLNC/Medical Concerns Decision Making Group.

The panel should call on others to provide specialist advice. This may include:

- a consultant from the same specialty or sub-specialty as the appellant but from another NHS employer. Where the case involves a dentist this may be a consultant or an appropriate senior practitioner

- a senior Human Resources specialist who may be from another NHS organisation.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

The Trust should make the arrangements for the panel and notify the appellant as soon as possible and, in any event, within the recommended timetable below. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner.

It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability hearing. The following timetable will apply in all cases:

- appeal by written statement, giving full grounds for the appeal, to be submitted to the designated appeal point (normally the Chief People Officer) within 25 working days of the date of the written confirmation of the original decision.

- hearing to take place within 25 working days of date of lodging appeal.

- decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

The timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The case manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

5.4.11 **POWERS OF THE CAPABILITY APPEAL PANEL**

The appeal panel has the right to call witnesses of its own volition but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.

Exceptionally, where during the course of the hearing, the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the Witness and made available to both parties before the hearing re-assembles.

If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal or whether the case should be reheard, on the basis of the new evidence, by a capability hearing panel.

5.4.12 **CONDUCT OF THE APPEAL HEARING**

All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence.

The practitioner may be represented and/or accompanied by a companion who may be another employee of the NHS body, an official or representative of the British Medical Association [or any other recognised trade union], British Dental Association or a defence organisation, or work colleague, a friend, partner or spouse. The companion may be legally qualified but they will not be acting in a legal capacity.

The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can, at this stage, make a statement in mitigation.

The panel, after receiving the views of both parties, shall consider and make its decision in private.

5.4.13 **DECISION**

The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's Case Manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chair of the appeal panel.

5.4.14 ACTION FOLLOWING THE HEARING

Records must be kept, including a report detailing the capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the capability procedure and the General Data Protection Regulations and current national Data protection legislations. These records need to be made available to those with a legitimate call upon them such as the practitioner, the regulatory body or in response to a direction from an Employment Tribunal.

5.4.15 TERMINATION OF EMPLOYMENT WITH UNRESOLVED PERFORMANCE ISSUES

Where a practitioner leaves employment before procedures have been completed, any outstanding disciplinary investigation will be concluded and capability proceedings will be completed where possible whatever the personal circumstances of the employee concerned.

Where employment ends before investigation or proceedings have been concluded, every reasonable effort will be made to ensure the former practitioner remains involved in the process. If contact with the practitioner has been lost, the Trust will invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The Trust will make a judgement, based on the evidence available, as to whether the allegations about the practitioner's capability are upheld. If the allegations are upheld, the Trust will take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, referral to the Local Authority Designated Officer (LADO) and the Disclosure and Barring Service.

If an excluded practitioner or a practitioner facing capability proceedings becomes ill, they will be subject to the Trust's Sickness Absence Policy. The sickness absence procedures take precedence over the capability procedures and the Trust will take reasonable steps to give the practitioner time to recover and attend any hearing. Where the practitioner's illness exceeds four weeks (or immediate if their absence is stress related) they must be referred to the Occupational Health department. The Occupational Health department will advise the Trust on the expected duration of the illness and any consequences it may have for the capability process and will also be able to advise on the practitioner's capacity for future work, as a result of which the Trust may wish to consider retirement on health grounds. The investigation should still be taken to a conclusion and the Trust form a judgement as to whether the allegations are upheld.

If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner for reasons of ill-health, the practitioner will have the opportunity to submit written submissions and/or have a representative attend in his/her absence.

Where a case involves allegations of abuse against a child, the guidance issued to the NHS in September 2000, called "The Protection of Children Act 1999 – A Practical Guide to the Act for all Organisations Working with Children" gives more detailed information. A copy can be found on the Department of Health website (www.dh.gov.uk/PublicationsAndStatistics).

5.5 HANDLING CONCERNS ABOUT A PRACTITIONERS HEALTH

A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress.

The Trust's key principle for dealing with individuals with health problems is that wherever possible, and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment rather than be lost from the NHS.

5.5.1 RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

Wherever possible the Trust will attempt to continue to employ individuals provided this does not place patients or colleagues at risk. In particular, the Trust will consider the following actions for staff with ill-health problems:

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated)
- remove the practitioner from certain duties
- re-assign them to a different area of work
- arrange re-training or adjustments to their working environment, with appropriate advice from PPA and/or Health Education England, under the reasonable adjustment provisions of the Equality Act 2010.

This is not an exhaustive list.

5.5.2 REASONABLE ADJUSTMENT

At all times the practitioner will be supported by the Trust and the Occupational Health (OH) department which will ensure that the practitioner is offered every reasonable resource available to get back to practice where appropriate. The Trust will consider what reasonable adjustments could be made to their workplace or other arrangements, in line with the Equality Act 2010. In particular, it will consider:

- making adjustments to the premises
- re-allocating some of a disabled person's duties to another
- transferring a practitioner to an existing vacancy
- altering a practitioner's working hours or pattern of work
- assigning the practitioner to a different workplace
- allowing absence for rehabilitation, assessment or treatment
- providing additional training or re-training
- acquiring/modifying equipment
- modifying procedures for testing or assessment
- providing a reader or interpreter
- establishing mentoring arrangements.

In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner. However, any issues relating to

conduct or capability that have arisen will be resolved using the appropriate agreed procedures.

5.5.3 HANDLING HEALTH ISSUES

Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine the underlying causes. If the report recommends OH involvement, the nominated clinical manager, with the support of a HR representative must immediately refer the practitioner to a qualified occupational physician (usually a consultant) with the Occupational Health department.

PPA should be approached to offer advice on any situation and at any point where the Trust is concerned about the health of a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.

The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with a HR Representative, the Medical Director or Case Manager, the practitioner and case worker from OH to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings. This could be another employee of the NHS body, an official or representative of the British Medical Association [or any other recognised trade union], British Dental Association or a defence organisation, or work colleague, a friend, partner or spouse. The companion may be legally qualified but they will not be acting in a legal capacity.

Confidentiality must be maintained by all parties at all times.

If a doctor or dentist's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work and referral to the professional regulatory body must be considered, irrespective of whether or not they have retired on the grounds of ill health.

In those cases where there is impairment of performance solely due to ill health, disciplinary procedures will be considered only in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the Trust to resolve the underlying situation, e.g. by repeatedly refusing a referral to OH or PPA.

There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the doctor or dentist to OH for assessment as soon as possible. Unreasonable refusal to accept a referral to or to co-operate with, OH under these circumstances may give separate grounds for pursuing disciplinary action.

Special Professional Panels (generally referred to as the "three wise men") were set up under circular HC(82)13. This part of the procedure replaces HC(82)13 which is cancelled.

6 TRAINING/SUPPORT

There are no specific training requirements in order to implement this policy.

Maintaining High Professional Standards Training will be provided for medical managers.

The Trust will provide training for Case Managers and Investigators and guidance for panel members.

The Trust will provide management resources to enable the effective execution of actions advised in this policy and will provide employee relations training sessions for managers.

PPA provides a range of core services to NHS organisations such as advice, assessment and intervention training courses and other expert services.

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	• Number of cases being managed in accordance with MHPS and/or Trust Disciplinary Policy and Procedure. • Number of exclusions • Number of referrals made to PPA. • Number of referrals made to GMC/GDC.
Lead	• Chief People Officer • Medical Director
Tool	• HR medical and dental case log
Frequency	• Monthly
Reporting Arrangements	• Medical Concerns Decision Making Group • Quarterly anonymised report to JLNC
Acting on recommendations and Lead(s)	• The Chief People Officer, in conjunction with the Medical Director, will be responsible for ensuring that appropriate recommendations are acted upon within reasonable time-frames.
Change in practice and lessons to be shared	• Required changes in practice and lessons to be shared will be identified and actioned within three months. A lead member of the team will be identified to take each change forward as appropriate. Lessons will be shared with all the relevant stake-holders.

8 EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employee.

9 REFERENCES

- Maintaining High Professional Standards in the Modern NHS (MHPS), Department of Health
- General Data Protection Regulations and current national Data Protection Legislation.
- Managing Allegations against Staff Policy – The Dudley Group NHS Foundation Trust
- Disciplinary Policy – The Dudley Group NHS Foundation Trust
- Trust Board Statement – Counter Fraud and Bribery – The Dudley Group NHS Foundation Trust
- Conduct Policy - – The Dudley Group NHS Foundation Trust
- Sickness Absence Policy - – The Dudley Group NHS Foundation Trust

10 APPENDICES

Appendix 1 – Terms of Reference Medical Concerns Decision Making Group

While statutory responsibilities in relation to the responsible officer regulations rest with the responsible officer, their decisions can often be assisted by suitable discussions with others, in terms both of supporting objectivity and usefulness.

Depending on the nature and scale of an organisation, arrangements for such discussions can be formalised by way of establishing a suitable group, comprising relevantly skilled and experienced colleagues.

The following terms of reference, which set out how the group will be constituted and its function described,

1. Terms of Reference Purpose

The purpose of revalidation is to provide assurance to patients and the public that licensed doctors are up to date and fit to practice. The Responsible Officer (RO) has a key role in ensuring the effective implementation of the Responsible Officer Regulations in their designated body.

An advisory group to support the role of the RO provides the opportunity for greater calibration of decision-making and the involvement of lay members. The group will provide input to the decision-making with regard to performance concerns about doctors, employment processes and any other aspects relevant to the RO Regulations.

2. Key objectives

The advisory group will consider key items requiring decision-making to support the role of the RO, including but not restricted to:

- Concerns regarding a doctor and the application of the organisation's Management of Conduct and Capability for Medical and Dental Staff Policy.
- Complaints to the RO about appraisal, revalidation or performance concerns processes
- Any other issues relevant to the role of the responsible officer
- Ensure that the well-being of the practitioner is considered at all points
- Ensure that the practitioner is kept informed at all stages of the process
- Ensure that the medical line manager is informed of the outcome
- Compile a quarterly report to the Board of all doctors managed under MHPs processes
- MCDMG is informed of the outcome of all cases by HR

Additional objectives may include:

- The provision of a forum where standards of medical practice are set and thresholds for raising and acting on concerns are monitored for consistency, both internally and externally

- The provision of a forum for discussing excellence in practice, encouraging development and identifying career opportunities for individuals

- The promotion of effective triangulation of information where there may be a number of potential sources of intelligence about an individual

- The provision of support to the RO in the oversight of remediation of doctors

3. Membership

The advisory group includes:

- Medical Director/Responsible Officer
- Deputy Medical Directors
- HR Director/Lead
- Chiefs of Service

Additional members may be requested to join as required for specific items / advice as required e.g. GMC Employer Liaison Advisor, Communications Lead, representative from a Royal College, NHS Resolution, Occupational Health, Clinical Director or Clinical Service Lead.

The chair will be the Medical Director/RO or deputy.

4. Quorum

A quorum will be three members from the above list including the chair for decisions to be valid.

Process

The Advisory Group exists within a system in the organisation for compliance with the RO Regulations. Although the RO holds the statutory responsibility for decisions gaining broader input from a wider group may be beneficial in ensuring consideration of all relevant aspects.

The Advisory Group will meet weekly and on an ad hoc basis if required. Meetings may take place using technology to avoid travelling where possible e.g. video or teleconferences.

Where urgent decisions are required additional meetings may be convened in a timely manner.

Discussions will be held on any issues relevant to decisions to be made by the RO.

Brief notes will be made of the discussions and decisions reached. If the Medical Director/RO is not present the key points from the meeting will be communicated to the RO as soon as possible after the meeting to inform decision-making.

Documentation will be stored securely in a restricted folder. Any papers printed and used during the meetings will be disposed of by confidential shredding following the meeting. A summary of decisions and actions will be provided at the start of subsequent meetings to update the group.

At the beginning of each case discussion members will be asked to disclose any conflict of interest, if a conflict of interest becomes apparent at any time members are expected to bring this to the group’s attention for a decision to be made whether to exclude them from further discussions.

The group will use the attached Risk Assessment Matrix to inform, support and to provide a degree of objective backing to professional judgement. It is not a validated tool and does not replace professional judgement. In addition the group will use the Just Culture Guide to support their decision making.

All discussions by the group will be treated confidentially and not discussed further outside the group except with express permission of the group.

For the purpose of calibration across designated bodies any relevant learning will be considered for sharing anonymously with others through the RO network.

Product

The product following the discussions by the group will be a recommendation for the responsible officer. The responsible officer will make decisions and determine actions based on the group's discussions and will feedback to the group at the next meeting.

Any learning identified through this process will be shared anonymously as appropriate e.g. with other responsible officers.

5. Review of term of reference

The term of reference for the Medical Concerns Decision Making Group will be reviewed annually by the Medical Director.

Risk assessment matrix

Using this risk assessment matrix

1. *Before looking at the matrix*, consider the issue and form an opinion as to whether the associated risk is low, medium or high using your professional judgement.

2. Only after you have done this, refer to the matrix.

    i. Consequence:

    Use Sections A or D to determine the consequence score based on whether the consequence listed can reasonably be viewed as having resulted from the actions of the doctor. You should do this in terms of both the incident that has occurred and the potential consequence should the same prompt occur again. All events, actual or future, may have one consequence or several consequences (e.g. affecting patient care, adverse publicity, etc.). The score used to calculate the overall consequence is the row from which the highest numerical score is achieved, whether considering the initial prompt or potential future consequences.

    ii. Likelihood:

    Use Section B to determine the likelihood score. This is the chance that the consequence described above will recur, or the frequency with which a similar incident has occurred in the preceding 12 months, whichever gives the greater score.

    iii. Risk Score:

    Section C. Multiply the consequence score with the likelihood score to obtain the risk rating, which will be a score between 1 and 100. A score of 0-8 = low risk, 10-18 = medium risk, 20-100 = high risk.

3. Compare the risk rating you arrived at in 1 above with the rating you reached in 2. If they concur, accept the risk. If they do not, revisit both ratings until you are satisfied that the risk is correct. If you cannot reconcile your professional judgement with the score obtained using the matrix, you should discuss with others until you are satisfied that the risk rating you are applying is that which is most appropriate to the circumstances.

4. The matrix is designed to measure the risk associated with an incident, not an individual. Once the incident risk is established, a further judgement is needed to establish the extent to which the incident is attributable to the actions of an individual and hence whether or not it should be regarded as a concern about medical practice.

Section A Common consequences
(see Section D for other consequences)
Actual Severity = Concerns/Incidents/Complaints/Claims Potential Severity = Risk Assessments/Near Miss

	2	4	6	10	20
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	No or trivial impact on patient health No or trivial impact on staff	Minimal impact on patient health requiring no intervention or treatment Staff distress or injury not requiring time off work	Minor impact on patient health, or intervention/treatment required, resolves within one month Staff distress or injury requiring time off work or light duties for 0–35 days	Moderate impact on patient health, or impact lasts longer than 28 days – patient recovered Staff distress or injury requiring time off work or light duties for >35 days with eventual recovery Major injuries/Dangerous Occurrences reportable under RIDDOR	Major impact on patient health, or impact is permanent or unexpected death Staff distress or injury which prevents work for the foreseeable future. All Never Events (Defined elsewhere)
Quality/ Complaints	Little or no patient dissatisfaction	Unsatisfactory patient experience relating to attitude or patient expectations of care where care has been within the normal surgery protocols Justified formal complaint peripheral to patient care Error of process – minimal potential for patient harm	Unsatisfactory patient experience relating to attitude or patient expectations of care, where the care has been outside normal local protocols Justified formal complaint involving lack of appropriate clinical care, short term effects Error of process with potential for patient harm	Non-compliance with widely agreed national standards Justified multiple formal complaints. Serious mismanagement of care, long term effects Potentially criminal behaviour Legal Claim Ombudsman Inquiry	Totally unacceptable level or quality of treatment/service, or overtly negligent or malicious behaviour by member(s) of team Probable or overt criminal behaviour
Fitness to practise	No indication of breach of GMP	Possible minor breach of GMP	Minor breach of GMP	Moderate breach of GMP	Major breach of GMP

Section B – Likelihood

	1	2	3	4	5
% Chance of recurrence of consequence in identified group in next 12 months	1-5%	6-25%	26-50%	51%-75%	76-100%
Number of times this has happened in the last 12 months	0-2	3-6	7-14	15-30	31+

Section C – Risk Score

Likelihood	Consequence				
	2	4	6	10	20
1	2	4	6	10	20
2	4	8	12	20	40
3	6	12	18	30	60
4	8	16	24	40	80
5	10	20	25	50	100

Section D – Less common consequences:

	2	4	6	10	20
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Objectives / Projects	Insignificant project slippage Barely noticeable reduction in scope or quality	Minor project slippage Minor reduction in scope or quality	Serious overrun on project Reduction in scope or quality	Project in danger of not being delivered Failure to meet secondary objectives	Unable to deliver project Failure to meet primary objectives
Service / Business Interruption Environmental Impact	Threatened Loss / Interruption of service Minimal or no impact on the environment including contamination, not directly coming into contact with patients, staff or members of the public	Loss / Interruption of service Up to 1 hour Minor impact on the environment	Loss / Interruption of service 1 to 4 hours Moderate impact on the environment	Loss / Interruption of service 4 hours to 2 days Major impact on the environment including partial closure	Loss / Interruption of service More than 2 days Major impact on the environment including full closure
Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory guidance	Breach of statutory legislation reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices low performance rating. Critical report	Multiple breaches in statutory duty Prosecution Complete system change required Zero performance rating Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Element of public expectation not being met	Local media coverage – long term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the house) Total loss of public confidence
Finance including claims	No obvious / small loss < £50	£50 - £500	£500 to £5000	£5000 to £50000	Over £50000

Appendix 2 – Risk Assessment Exclusion

Exclusion should only be considered when it is anticipated that an individual remaining at work may cause a risk to patient care, members of staff or the investigation. Temporary redeployment to an alternative role, restrictions on practice or increased supervision should always be considered and if appropriate, put in place for the duration of the investigation as an alternative.

This risk assessment tool is to be used prior to any decision being taken about whether to exclude, redeploy or amend the duties of a practitioner. It should be completed by the individual who has the authority to exclude with advice and support from a senior HR practitioner.

The authority to exclude a member of staff is vested in:

- The Chief Executive and their deputy
- The Medical Director and their deputy
- The Chief People Officer and their deputy

Date:	
Manager:	
HR Practitioner:	
Staff Member:	
Department:	
Issue/Incident:	
Reported by:	
Evidence obtained prior to risk assessment	

Risk Analysis (see table below for grading)

Risks	Yes	No	Risk Likelihood (L)	Risk Consequence (C)	Score (LxC)
Harm to patients					
Harm to employees					
Harm to self					
Harm to Trust					
Risk of continued fraud					
Risk to service provision					
Risk to investigation process					
Some other substantial reason					

	Likelihood (L)				
Consequence (C)	1 – Rare	2 – Unlikely	3 – Possible	4 - Likely	5 – Almost Certain
5 – Catastrophic	5	10	15	20	25
4 – Major	4	8	12	16	20
3 – Moderate	3	5	9	12	15
2 – Minor	2	4	6	8	10
1 – Negligible	1	2	3	4	5

	1-3 low risk		4-6 medium risk		8-12 high risk		15-25 extreme risk

Actions to be taken to reduce risk:

Risk	Mitigation Action	New Risk Rating (following implementation of mitigation action)

Decision on outcomes following risk analysis

Risk Options	Yes	No	Reason for Risk option
No requirement to take action identified			
Manage the risk and allow staff member to remain within their role under close supervision			
Reduce the risk and limit duties and role under supervision within the same workplace			
Transfer the risk and redeploy the staff member temporarily to alternative employment within the Trust			
Avoid risk and exclude staff member			

Signed:	**Date:**

Name & Job Title	
Signed:	**Date:**
Name of HR Practitioner:	

Appendix 3 – Impact Assessment Tool: overlapping Employee Relations processes

No processes should be delayed where, to do so would impact on patient and/or staff safety.

This impact assessment tool is to be used prior to any decision being taken about whether to temporarily suspend a process in order to deal with counter allegations. It should be completed by the case manager with advice from Human Resources.

Current investigation details:	
Counter allegation details:	

Please complete the risk analysis below to ascertain whether the suspension of the current investigation may have a detrimental impact on patient or staff safety.

Risk Analysis (see table below for grading)

Risks	Yes	No	Risk Likelihood (L)	Risk Consequence (C)	Score (LxC)
Harm to patients					
Harm to employees					
Harm to self					
Harm to Trust					
Risk of continued fraud					
Risk to service provision					
Risk to investigation process					
Some other substantial reason					

	Likelihood (L)				
Consequence (C)	1 – Rare	2 – Unlikely	3 – Possible	4 - Likely	5 – Almost Certain
5 – Catastrophic	5	10	15	20	25
4 – Major	4	8	12	16	20
3 – Moderate	3	5	9	12	15
2 – Minor	2	4	6	8	10
1 – Negligible	1	2	3	4	5

1-3 low risk	4-6 medium risk	8-12 high risk	15-25 extreme risk

Actions to be taken to reduce risk:

Risk	Mitigation Action	New Risk Rating (following implementation of mitigation action)

Decision on outcomes following risk analysis

What action do you intend to take in relation to the current investigation:	
What action do you intend to take in respect of the counter allegation?	

Signed:	**Date:**
Name & Job Title	
Signed:	**Date:**
Name of HR Practitioner:	

Appendix 4 – Summary of rights of a practitioner under the maintaining high professional standards for medical and dental staff

If a practitioner is subject to formal action under the policy for Maintaining High Professional Standards for Medical and Dental Staff, his/her rights (once formal action is initiated) are:

1. to be accompanied and/or represented from the outset, by an official or lay representative of a professional organisation or defence organisation, a work colleague or a friend, partner or spouse. Where any of the above is legally qualified they will not be able to act in a legal capacity.

   Sufficient time will be allowed for the representative or companion to offer advice and prepare the case. The companion may be legally qualified but they will not be acting in a legal capacity. Management will give the maximum assistance in securing representation promptly so the matter can be resolved without unnecessary delay

2. to be advised of the details of the alleged misconduct in writing prior to the interview

3. to be told of the category of the alleged misconduct

4. entitlement to all information relating to the allegations

5. to be given on request a copy of any disciplinary action which is retained on the employees' personal file

6. to be reminded in writing of his/her right of appeal in matters classed as serious or gross misconduct.

   Any investigative report commissioned by the case manager remains the property of the Trust. Summary of the findings and recommendations may be made available to give the opportunity to modify actions/behaviours. Any documents may eventually be disclosed in the event of a dispute being referred to in a court of law.

   It should be noted that different rights apply in processes administered by other agencies (for example the police and the counter fraud service). The procedures operated by these agencies are governed by legislation over which the Trust has no control.

Appendix 5 Guidance/support for a practitioner when dealing with an issue

When a concern arises, share information about it with the doctor as soon as is practically reasonable to do so – in person or by telephone, in preference to email. At the same time, consider your timing – depending on the severity of the matter it may be more sensitive not to inform a doctor about a new concern at 4:45pm on Friday, or immediately prior to their going on annual leave.

Agree a suitable venue and mutually convenient time to meet and discuss it.

Before meeting, discuss with the doctor whether or not you meet one-to-one or with others present in support. Consider the level of risk you have identified when considering this, and the degree of engagement/insight that currently exists. For an issue of low concern and where the doctor is fully engaged it would be common to meet without anyone else, whereas for high concern issues it might be necessary for both you and the doctor to have support in the form of a person to keep notes or other advisor, e.g. a colleague, defence organisation, local medical organisation (LNC/LMC) or legal representative. If you have agreed to meet alone, it is important to record this agreement in your agreed final notes of the meeting.

At the meeting, put aside time to meet with doctor and avoid interruptions. Arrange seating so you can make eye contact. Take time to set the scene, with introductions, including clarity on the role in which you are meeting the doctor.

Be polite and respectful, remain professional and avoid getting drawn in to arguments even if the doctor becomes challenging, aggressive or challenges your personal integrity. Focus on the facts. Explain how the information reached you, why you are concerned, any actual or potential risks to patient safety.

Explain the shared duty on all parties to maintain a professional approach to responding to the matter and working together to identify the cause and agree appropriate action. Refer to the professional requirements outlined in Good Medical Practice.

Explain the role of the responsible officer with regard to their whole scope of work and ask the doctor to confirm any other roles outside the organisation. You may need to make contact with persons with governance responsibility for the doctor's practice in other organisations where the doctor works or ask the doctor to share information as appropriate with other places of work.

Try to understand how the doctor is feeling having had concerns raised about their practice. Putting the incident/complaint/concern in context may be helpful. For example knowing that the matter has a low level of risk or explaining the proportion of doctors that commonly receive complaints or are involved in incidents may be helpful for the doctor.

Allow the doctor time to remember and describe their version of events.

Explore sensitively but explicitly with the doctor whether there may be any relevant health issues.

Explore sensitively but explicitly whether there need to be any amendments to the doctor's usual duties while the matter is being assessed. Make it plain that any action of this nature will be based on an assessment of risk and that any exclusion from practice or amendment to duties will only take place if absolutely necessary in the interests of patient safety. If duties are being amended, take care to confirm that this is a neutral act and that the doctor

understands and accepts this. Reassure them that this matter will be sensitively handled in terms of confidentiality, with only those who need to know being informed of the minimum necessary facts. If you feel adjustment of duties is necessary, including full removal from the workplace, asking the doctor to voluntarily withdraw or amend their duties (if compatible with local policy) may receive a more positive response than the imposition of restrictions to practice. Ensure that there is clarity on exactly what has been agreed and document this.

Discuss with the doctor any requirements to inform patients/relatives in accordance with the Duty of Candour Regulations.

Take notes of the meeting and send to the doctor afterwards and ask them to confirm their agreement to the record. It may be helpful to provide a leaflet/guidance document for doctors so they have reference to written information after the meeting.

Explain what the next steps are and ensure that there are arrangements in place to continue to meet with and communicate with the doctor at regular intervals.
If a full investigation is required, explain how this will take place, who the investigator will be (if known) and the terms of reference.

If during the discussion it is agreed that access to a mentor or coach may be helpful, provide details of how the doctor can access this.

Appendix 6 – Sample Terms of Reference for Formal Investigation

STRICTLY PRIVATE AND CONFIDENTIAL

TERMS OF REFERENCE FOR INVESTIGATION REGARDING [INSERT NAME]

Case Investigator:	[Insert name]
HR support:	[Insert name]
Case Manager:	[Insert name]
HR Support	[Insert name]
Date:	[Insert]
Target date on which investigation should be completed	[Insert]
Target date on which Investigation Report should be produced to Case Manager:	[Insert]

1. Introduction

You are requested to act as case investigator in respect of serious allegations that have been made against [Insert name].

[Insert name], will provide human resources and assistance and advice in respect of the investigation.

You should carry out a full investigation into the issues of concern outlined below and produce a full investigation report confirming the evidence, your findings in accordance with Management of Professional Conduct and Capability for Medical and Dental Staff Policy (Maintaining High Professional Standards in the Modern NHS).

As case manager I have carried out an initial assessment of the issues of concern. This is an initial assessment and your investigation is not bound and should not be influenced by my initial conclusions and your investigation must not be limited to this information alone.

2. Issues to be investigated

I would like you to fully investigate the following concerns in order to determine the facts in relation to the concerns which have arisen and produce a full investigation report confirming the evidence and your conclusions and appropriate findings in accordance with MHPS:

(i) To ascertain if, ...

(ii) If.....

(iii) To further investigate whether .....

(iv) If.....

3. Methodology

We suggest:
Interviews take should take place with relevant witnesses and any relevant documentation relating to the issues to be investigated should be collated to establish the facts and to enable a report in the findings.

As case investigator, you should collect written statements where possible, and if any aspect of the investigation is not covered by a written witness statement you should ensure that the oral evidence is fully set out in the Investigation report.

You must ensure the investigation is conducted confidentially and that breaches of confidentiality are avoided as far as possible.

The case investigator has discretion as to how the investigation is carried out, but the purpose of the investigation is to ascertain the facts in an unbiased way.

All relevant Trust protocols for risk management, incident reporting, drug errors and maintaining of patient records should be considered by you, as case investigator.

Initial Witness identified:
Using your discretion, you should identify and interview any further relevant witnesses who it becomes evident need to provide information in order to establish the facts.

Please produce a statement for each witness, signed, and again attach these as appendices to the final investigation report.

4. Additional issues identified by the Case Investigator

Should you identify additional issues of concern outside of the issues identified at section 2 above you should inform me of these additional issues so that I can consider whether they should be included in the investigation.

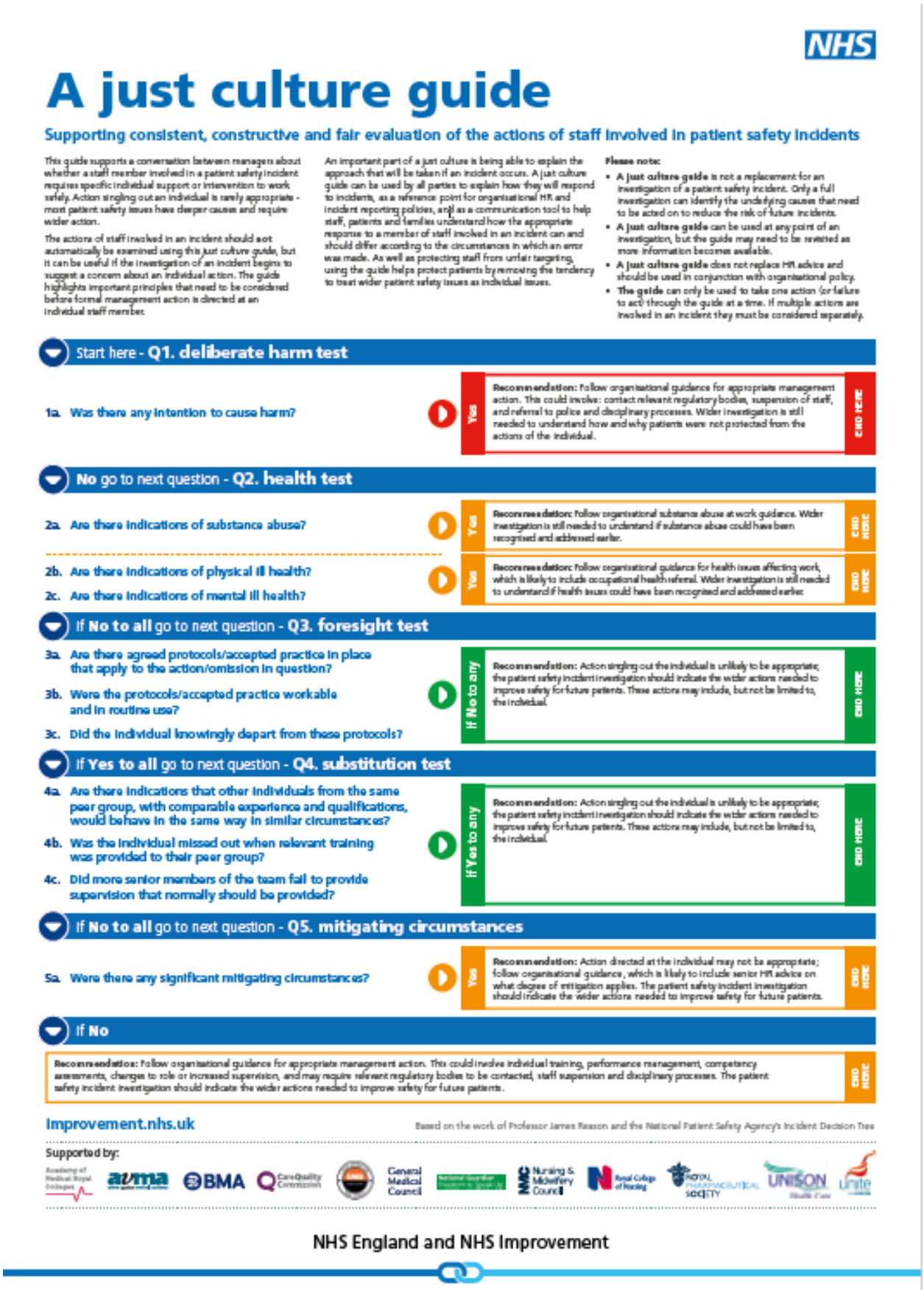
5. Outcome
You should produce a report which includes a written record of the investigation, setting out the facts established by the investigation in respect of the issues to be investigated (set out above) and which reports the investigation findings.

The investigation report should provide sufficient information to allow me, as case manager to make a decision as to what further action, if any, should be taken. You should not make a decision as to what action should be taken and should not set out any decision in the investigation report.

Insert name [of case manager]
Title
[Insert date]

Appendix 7 – Just Culture Guide

https://improvement.nhs.uk/resources/just-culture-guide/



NHS

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should not automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. **END HERE**

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

If No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

If Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

If No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

If No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

Improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement