Managing Concerns about the Conduct, Performance and Health of Medical and Dental Staff Policy

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Lead Executive/ Senior Manager	Chief Medical Officer and Chief People Officer		
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Consultation	Local Negotiation Committee	**Applicable to:**	All Medical and Dental Staff
Equality, Diversity And Human Right Statement	The Trust is committed to an environment that promotes equality and embraces diversity in its performance both as a service provider and employer. It will adhere to legal and performance requirements and will mainstream Equality, Diversity and Human Rights principles through its policies, procedures, service development and engagement processes. This procedure should be implemented with due regard to this commitment.		
To be read In conjunction with / Associated Documents:	• Disciplinary Policy • Alcohol and Substance Misuse Policy • Sickness Management Policy • Bullying and Harassment Policy • Appraisal and Revalidation Policy	**Information Classification Label**	☐ **Unclassified**
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Document Change History (changes from previous issues of policy (if appropriate):

Version number	Page	Changes made with rationale and impact on practice	Date
1	All	New policy	March 2020
2	All	Minor changes to policy following changes to DMS	March 2022

Contents

1. Overview

1.1 Purpose and Rationale

This policy provides a clear set of procedures for handling potential concerns about the conduct, performance, or health, of medical or dental staff (henceforth referred to as practitioners). The purpose of this policy is to support the delivery of a transparent, fair, and systematic approach to dealing with these challenging and often complex issues, ensuring patient safety is the paramount consideration.

The policy is based on the national framework ***Maintaining High Professional Standards in the Modern NHS* (2005)**[1] and takes into account changes in the professional regulation of doctors introduced by NHS England in ***The Medical Profession (Responsible Officers) Regulations 2010***[2] and ***The Medical Profession (Responsible Officers) (Amendment) Regulations 2013***[3].

The policy also incorporates guidance from NHS England in ***A practical guide for responding to concerns about Medical Practice (2019)***[4] and the ***GMC principles of a good investigation***[5] and it reflects current practice in large secondary care Trusts in England.

1.2 Summary of Contents

This policy covers:

- action to be taken when a concern first arises about a practitioner, including considering the need to exclude from work or place restrictions on their practice
- the conduct of investigations
- the conduct of hearings
- disciplinary procedures
- dealing with capability issues
- handling concerns about a practitioner's health

1.3 Future Amendments

This policy may be amended from time to time to reflect any future national guidance, through agreement with the Local Negotiating Committee (LNC). Where any conflict of interest arises, or a lack of clarity exists, the current nationally agreed guidance will take precedence.

1.4 Key abbreviations

RO - Responsible Officer,
ROAG Responsible Officer Advisory Group
PPA Practitioners Performance Advice
GMC General Medical Council (the medical regulator)
GDC General Dental Council (the dental regulator)

HEENW – Health Education England (North West)
TRES – Trainees Requiring Extra Support
GMC ELA – Employer Liaison Advisor
MD – Medical Director
CD – Clinical Director

2. Scope

This policy applies to all practitioners whose designated body is LUHFT ie, practitioners directly employed by LUHFT, including those on short-term contracts and Trust-employed trainees, and practitioners employed on honorary contracts. The policy also incorporates references to the processes to be followed when issues arise with practitioners not directly employed by the Trust ie, trainees with a national training number and practitioners employed through locum agencies.

3. Background

4.1 Medical/Dental Regulation is a multi-layered process which includes

Personal regulation: Practitioners are expected to behave with personal integrity, to take responsibility for their clinical and ethical practice, and to recognise the limits of their competence.

Team-based regulation: Each member of the medical/dental team has a responsibility for ensuring their colleagues act appropriately and that any risk posed to patients by a member of the team is identified early and addressed.

Local regulation: Employers should have adequate clinical governance arrangements to ensure doctors are competent and fit to practise, and concerns are identified and addressed as soon as possible.

National regulation: The GMC/GDC focuses only on the most serious concerns.

4.2 Guiding principles for responding to concerns about a practitioner's practice:

- 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 equity, equality and fairness.
- All information must be safeguarded.
- Support must be provided to all those involved.

From ***Supporting Doctors to Provide Safer Healthcare*** (NHS Revalidation Support Team, 2013 (revised)).

4.3 Doctors and Dentists in Training

Trainees with Health Education England North West (HEENW) who have national training numbers are employed by the Lead Employer (St. Helens & Knowsley Teaching Hospitals NHS Trust) and are professionally responsible to the Postgraduate Dean for HEENW who is their Responsible Officer (RO). All concerns about the conduct or capability of practitioners in training will be brought to the attention of the Trust's Directors of Medical Education by the doctor's Educational Supervisor or Clinical Director. When the concerns raised are serious, the RO for HEENW will be involved from the outset, and the RO and Chief Medical Officer (CMO) of LUHFT will also be informed. In summary, the flow for reporting concerns is as follows:

Clinical Supervisor ⇨Educational Supervisor⇨Departmental College Tutor and Director of Medical Education⇨ HEENW RO

Concerns about the capability of doctors and dentists in training should be considered initially as training issues.

Action taken regarding critical incidents involving trainees will be in accordance with HENW procedure. The police will be informed in cases where a criminal offence may have taken place. Guidance on reporting doctors and dentists to the GMC and GDC respectively must be followed. PPA may also be consulted.

See ***Trainees Requiring Extra Support (TRES) Health Education England Referral Guide*** [6]

For further details on supporting HEENW trainees and the Flow Chart for Trust

Flow Chart for Trust Incident Reporting to

Flow chart for Trust Incident Reporting to HEE NW embedded here.

<u>Trust –employed trainees</u>

Trust-employed trainees are not connected to HEENW. Concerns raised about these practitioners are managed according to this policy. The flow for reporting concerns is as follows:

Clinical Supervisor ⇨ Educational Supervisor and Clinical Director ⇨ Director of Medical Education⇨ RO/CMO for LUHFT

4.4 Locums employed via agency

Incidents which occur at LUHFT involving locums employed via an agency will be investigated by LUHFT and the outcome of the investigation will be communicated to the locum practitioner and to their RO. The practitioner's RO will be informed of serious incidents from the outset.

4.5 Practitioners with honorary contracts at LUHFT

The Trust has developed strong co-partnership relations with local universities including the University of Liverpool, Edge Hill University, John Moore's University and Chester University, to ensure that jointly agreed procedures (agreed through the Trust,

the LNC and the University) are in place for dealing with concerns about practitioners with honorary contracts. See:

Appendix Four *Disciplinary protocol between the University of Liverpool and NHS Trusts and Provider Units based on Maintaining High Professional Standards in the Modern NHS Guidance on Clinical Academics JUNE 2005*

Appendix Five *Joint Framework for Managing Clinical Academics*

Appendix Six *Joint Policy for Investigation into Research Misconduct between the University of Liverpool and the Trust.*

5. Policy

5.1 Responding to Concerns

5.1.1 Guiding principles for responding to a concern about a practitioner's practice:

The management of performance is a continuous process intended to identify concerns and determine if appropriate remedial and supportive action can be taken quickly before the matter becomes serious or patients come to harm.

Low level concerns

Effective clinical governance processes should mean only those matters that need to be, are brought to the attention of the RO/Responsible Officer Advisory Group (ROAG). Low-level concerns about practitioners should ideally be managed locally, in a positive, sensitive, and supportive manner, by the Clinical Lead or CD, with escalation to the Divisional MD and hospital site MD in turn, if necessary. It may be helpful to consult the Preliminary Fact-Finding Checklist from LUHFT's Disciplinary Policy, included in **Appendix Seven**, when making a decision about the need to escalate a concern. The Clinical Lead / CD / MD should keep a record of low-level concerns, and how they were addressed, to reference if further concerns arise. It is also important to allow individuals the opportunity to reflect on concerns raised about their practice at appraisal.

Not all concerns will require the formal processes set out in this policy. Adverse events may not be due to the unsafe actions of an individual alone. Root cause analysis of such events may reveal these to be attributable to systems or organisational failures which require remedial actions, or to untoward outcomes which could not have been predicted.

Unfounded and malicious allegations can cause long-lasting damage to a practitioner's confidence, reputation, and career prospects. Therefore, all concerns or allegations will be investigated appropriately, thoroughly, and as quickly as possible. A clear record will be kept of the process for initiating and tracking the progress of the investigation and resulting action. The Trust will adhere to the recommendations made by NHS England in 2019 in "Learning Lessons to improve people's practices" (**Appendix Eight**)

5.1.2 Definition of a concern

The NHS Revalidation Support Team (2013) defined a concern as:

"*Where the behaviour of a doctor causes or has the potential to cause harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes or appears to behave persistently in a manner inconsistent with the standards described in* ***Good Medical Practice*** [7]."

Behaviours that may give rise to concern particularly if persistent or recurrent include:

Performances issues:

- Absence from duty/persistent lateness
- Poor time management/backlog of work
- Failure to learn and change
- Over-or under-investigating
- Poor decision making
- Poor record keeping
- Failure to follow guidelines
- Missed or incorrect diagnoses

Behavioural issues

- Failure to engage with contractual or regulatory requirements eg job-planning, appraisal, or mandatory training without clear and agreed mitigating circumstances. Please note there may be a suspension of pay progression or the ability to apply for clinical excellence awards until the issue is resolved.
- Arrogance
- Lack of insight/denial
- Failure to support junior colleagues
- Poor team working
- Bullying, harassment, or undermining
- Poor or inappropriate communication with patients or colleagues
- Dishonesty
- Sexual misconduct
- Criminal acts

5.1.3 Modes of presentation of a concern

- From other NHS professionals, health care managers, students or non-clinical staff
- Complaints about care by patients or their relatives
- Monitoring of data on performance and quality of care
- Review of performance against job plans
- Clinical governance, clinical audit and other quality improvement activities
- Annual appraisal or revalidation considerations
- Information from the GMC, GDC or other regulatory bodies
- Litigation following allegations of negligence
- Information from the police or coroner
- Court judgements

5.1.4 Key stages of a process to address a concern:

a: Presentation
b: Exploration:
i: Immediate response
ii: Preliminary fact-finding enquiry
iii: Full formal investigation
c: Actions
d: Review

The process is dynamic rather than linear. Various factors such as the occurrence of new incidents, the discovery of new information, and failure of agreed action to achieve the desired outcome, may necessitate repeating one or more loops of the process.

5.1.5 Immediate Response when a concern arises

A preliminary discussion will be held at the earliest opportunity when a concern is escalated to the RO/ROAG. Such discussions will take place immediately on the day of escalation in the case of serious concerns. The RO/ROAG will then proceed as follows:

- Speak with the practitioner, face to face if possible.
- Inform the practitioner of their right to be accompanied. The companion may be another NHS employee, an official or representative of the British Medical Association (BMA)/British Dental Association (BDA), a defence organisation representative, a friend, partner, or spouse. The companion may be legally qualified, but they will not be acting in a legal capacity.
- Gather information to identify the nature of the problem, decide whether the matter constitutes a concern, and assess the seriousness based on information available.
- Decide whether:
    - The allegation appears unfounded
    - There is a potential misconduct issue
    - There are concerns about serious dysfunctions in the operation of a clinical service
    - There are serious concerns about a practitioner's lack of capability or poor performance, or
    - The complexity of the case warrants further detailed investigation.
- Decide whether an initial enquiry or a full investigation is required, or whether the matter can be resolved immediately.
- Discuss the case with the GMC ELA.
- Consider whether it is necessary to discuss the case with PPA. The RO or other member of the ROAG will make the first approach to PPA. PPA must be involved at an early stage if exclusion is being considered so that alternatives to exclusion can be explored.
- Consider whether a referral to Occupational Health (OH) is necessary.
- Consider whether amendment of duties is necessary or if exclusion is necessary and, if so, whether this should include a bar from the Trust's premises (see **5.2.1**).

    Rules of thumb when considering suspension/exclusion or amendment of duties:

  - Is any person's safety at risk?
  - Is evidence at risk (particularly criminal)?
  - Is suspension/exclusion necessary and proportionate to these risk(s)?
  - Is voluntary withdrawal/amendment a legitimate option?
- Consider whether it is necessary to speak to the CEO, the Trust Communications Lead, or with the person with governance responsibility in other organisations where the practitioner is working.
- Consider if a referral to the Police and/or the Counter Fraud and Security Management Service is necessary.
- Consider whether it is appropriate to request the issue of a Healthcare Professional Alert Notice (HPAN) by NHS Resolution.
- **Support** Put in place any necessary support for the practitioner involved, the person(s) who raised the concern, or both. In this context matters of equality and diversity may be relevant. Issues relating to protected characteristics must be considered in accordance with statutory requirements and LUHFT policy. Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.[9]
- Keep detailed factual records from the beginning of the process to support action which may need to be taken as the case progresses. Documentation should include the agreed actions taken, including a decision to take no further action, with timings.

5.1.6 Preliminary Fact-Finding Enquiry

- Consistent with the application of 'Just Culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.
- If the matter does not require immediate removal of the doctor from work or notification of the authorities, but cannot be resolved without further exploration or action, an initial enquiry is required. An initial enquiry should normally take no longer than 28 days.
- Effective engagement of the practitioner will help ensure the best outcome. They should be included in the process and, if possible, continue in their normal duties.
- The initial enquiry may necessitate the cross-referencing of information from those with governance responsibility for the doctor's practice in other places where the doctor works. The decision to do so should be shared with the doctor.
- The RO/ROAG will provide written terms of reference on the scope of the enquiry to the person leading the enquiry, The Preliminary Fact-Finding Checklist from LUHFT's Disciplinary Policy in **Appendix Seven** may be considered in drawing up the Terms of Reference.
- If there is agreement between the practitioner and RO/ROAG that the facts have been established sufficiently by the initial enquiry to allow a safe and fair

conclusion, the investigation is concluded. The process is documented including any actions required, with agreed timescales and review dates.

- **Informal Resolution**

If it is agreed that the matter is of low risk and does not constitute a concern, an informal approach can be taken to address the problem. Alternatively, it may be addressed as an incident within routine governance processes or without any further action. The issue will be recorded so that it can be considered should a further prompt arise.

Where an informal route is chosen, PPA may still be involved until the problem is resolved. This may include a formal clinical performance assessment where all parties agree this could be helpful in identifying the underlying cause of the problem and possible remedial steps.

Where it is identified that concerns are due to systemic/process weaknesses rather than the fault of the individual, an action plan is agreed with the practitioner and their line manager, CD or DMD as appropriate, with agreed timescales and review dates.

5.1.7 Full formal Investigation - process

When a concern about a practitioner arises, preliminary discussions by the RO ROAG, with input from the GMC ELA and PPA, may conclude from the outset that a full investigation is required. Alternatively, a full investigation may be needed following a fact-finding enquiry if the practitioner or the RO / ROAG are not in agreement that the facts have been established and a satisfactory conclusion reached. When a full formal investigation is required, the RO / ROAG will ensure completion of the following tasks by a nominated individual, within agreed timescales:

- Notification of the CEO
- Making a request to the Chairman or Trust Corporate Secretary to designate a Non-Executive Director (Designated Board Member) to oversee the case investigation.
- Appoint an appropriately a trained Case Manager and Case Investigator, considering the grade of the practitioner involved. An external investigator may be appointed where deemed appropriate.
- Ensure **formal exclusion** takes place having first considered, in consultation, whether there is reasonable and proper cause to exclude.
- **Exclusion from Premises** Consider whether exclusion should include a bar from the premises, and, if so, why. Practitioners will not normally be automatically barred from the Trust's premises upon exclusion from work. However, in certain circumstances it will be necessary e.g.
    - where there may be a danger of tampering with evidence
    - where the practitioner may be a serious potential danger to patients or other staff.
- Inform the Trust Board of any exclusion at the earliest opportunity.
- Refer the practitioner to OH where an incident points to a problem with a practitioner's health or where the practitioner is considered vulnerable because of the investigation process.
- Maintain contact with and update PPA as appropriate.

- Ensure there is continuing support from named individual(s), with a communication plan, for the practitioner involved and the person(s) who raised the concern.

5.1.8 Roles and Responsibilities of the Case Manager

The Case Manager must have undergone appropriate training and will work closely with the Chief People Officer, or deputy, and consult PPA if necessary:

(i) The Case Manager, with support from HR, will provide the Case Investigator with clear Terms of Reference.

(ii) The Case Manager will contact the practitioner concerned as soon as it has been decided that an investigation will be undertaken and advise them of the process that will be followed. Wherever possible the Case Manager will inform the doctor face to face and, where this is not possible, by video link or telephone. The information given will be confirmed in writing.

<u>The practitioner will receive the following information from the Case Manager</u>:

- The specific allegations or concerns that have been raised.
- Inform the practitioner of their right to be accompanied (see **Section 5.1.5**)
- The name of the Case Investigator.
- The support available from the Trust, a named mentor, or external bodies, as regards their health and wellbeing.
- The name of the Designated Board Member (Non-Executive Director) overseeing the investigation.
- They will be given the opportunity to see any correspondence relating to the case, including the Terms of Reference for the investigation, together with a list of people the Case Investigator will interview.
- They will be given the opportunity to put their view of events to the Case Investigator.
- A communication plan for the period of investigation.

(iii) <u>Managing Exclusions/Restrictions to Practice</u>

Where practitioners have been excluded, the Case Manager will manage the exclusion process as outlined in **5.2** which includes:

- Review exclusion before the end of each 4-week period and ensure the outcome is reported to the RO/ROAG, CEO and Trust Board.
- Refer to PPA for advice when they consider exclusion needs to be extended over a prolonged period outside their control.
- The same time frames as those outlined to review exclusions will be applied to reviewing restrictions on practice, although the requirement for reporting to the Trust Board does not apply.
- Inform the RO / ROAG if at any time during the investigation it is revealed that the allegations are unfounded so that the exclusion / restrictions to practice can be lifted or that further investigation can continue with the practitioner working normally or with restrictions.

(iv) If during the investigation it transpires the case involves more complex clinical issues than first anticipated, the Case Manager should discuss with the RO/ROAG whether an independent practitioner from another NHS body should be invited to assist.

(v) The Case Manager will consider requests for extension of time for the investigation from the Case Investigator.

(vi) On conclusion of an investigation, the report is reviewed by the Case Manager to determine whether there is a case to answer and if so, whether the 'Fair Blame' route may be offered, or a full hearing is required.

(vii) The Case Manager will ensure an OH referral is made if the practitioner is considered vulnerable because of the investigation process, becomes ill during disciplinary or capability proceedings, or where the practitioner subject to disciplinary procedures puts forward a case on health grounds, therefore delaying disciplinary, modifying, or terminating proceedings.

(viii) The duty to protect patients is paramount. If at any point in the process a judgement is reached by the Case Manager that the practitioner is considered a serious potential danger to patients or staff, the RO will consult with PPA and discuss referral to the GMC with the GMC ELA.

(ix) The Case Manager's report to the Board will be advisory. It will be for the CMO and Chief People Officer to decide on the next steps as appropriate.

(x) The role of the Case Manager in a Capability Hearing is outlined in **section 5.7** of this policy.

5.1.9 Role and Responsibilities of the Case Investigator

The role of the Case Investigator is to ascertain the facts of the case in an unbiased manner. In the interest of fairness, any potential conflict of interest will be considered before a Case Investigator is appointed. Where possible and appropriate, the Case Investigator will have relevant clinical expertise in cases involving clinical issues. The seniority of the Case Investigator will be determined in relation to the grade of the practitioner involved. Identified clinical managers and, where determined, non-clinical managers, will be appropriately trained to enable them to carry out this role when required. Where a non-clinical manager is appointed as Case Investigator, a senior doctor with relevant clinical expertise, who is not directly involved in the case, will be assigned to provide the Case Investigator with appropriate clinical information and advice where necessary. Similarly, a clinical manager who is appointed as Case Investigator will have the support of a non-clinical manager, if necessary.

The Case Investigator will be responsible for leading the investigation, establishing the facts, and reporting the findings. The Case Investigator has wide discretion on how the investigation is undertaken. However, the purpose is always to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner; information gathered during an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter. They will:

- Decide what information needs to be gathered and how it will be gathered.
- Ensure sufficient information is gathered to enable a safe and fair conclusion to be reached.
- Assist the designated board member in reviewing the progress of the case.

- Formally involve a senior member of the medical/dental staff where a question of clinical judgement is raised during the investigation process.
- Provide, if available, a preliminary report for any case conference to consider exclusion.
- Obtain appropriate professional advice in cases involving issues of professional conduct.
- Ensure sufficient written statements are collected to establish a case prior to a decision to convene a disciplinary panel or, where aspects of the case are not covered by any written statement, there is oral evidence of sufficient weight in the investigation report.
- Ensure safeguards are in place throughout the investigation so that breaches of confidentiality are avoided. Patient confidentiality must be maintained but any disciplinary panel will need to know the details of the allegations.
- Ensure a written record is kept of the investigation, the conclusions reached, and the course of action agreed.
- The Case Investigator will not make decisions on the course of action to be taken following conclusion of the case investigation and they will not be a member of the disciplinary or appeal panel relating to the case.
- If possible, the Case Investigator will complete the investigation within 8 weeks of their appointment and submit the report to the Case Manager within a further 5 days. For complex cases, this timescale may be extended by mutual agreement, following consultation with the practitioner, their representative and PPA. The investigation report will give the Case Manager sufficient information to decide whether:
    - There is a case of misconduct that should be put to a conduct panel.
    - There are concerns about the practitioner's health that should be considered by OH.
    - 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.
    - There are serious concerns that should be referred to the GMC / GDC.
    - There are intractable problems, and the matter should be put before a capability panel.
    - The matter can be dealt with on an informal basis.
    - No further action is needed.

5.2 Exclusion From Work and Restriction on Practice

5.2.1 Formal Exclusion

A formal exclusion will take place only after a case conference has considered there is a case to answer and then considered whether there is reasonable and proper cause to exclude. Prior to an exclusion, the case will be discussed with PPA, the GMC ELA, the CEO, and other interested parties such as the police, or the Counter Fraud and Security Management Service where there are serious criminal allegations. In the rare cases where immediate exclusion is required (see **5.2.4**), the above parties must discuss the case at the earliest opportunity following the

exclusion, preferably at a case conference.

Formal exclusion of a practitioner will be regarded as a temporary, precautionary measure and not a disciplinary sanction, and will be applied only in the most exceptional circumstances to protect the interests of patients, other staff, or the practitioner concerned. The legitimate reasons for exclusion are limited to those in the MHPS framework. It is important when considering an exclusion that these limitations guide any decision and there is a full exploration of the possible alternatives to exclusion. NHSR has created a flow chart to help decision making and management of the exclusion process:
Exclusions process to ensure compliance with good practice (resolution.nhs.uk)

5.2.2 Alternatives to exclusion

Alternatives to exclusion will always be considered, including:

- Supervision of normal contractual clinical duties by Clinical Lead or CD.
- Restriction of the practitioner to only specified clinical duties.
- Restriction of activities to administrative, research, audit, teaching or other educational duties which, in the case of the latter, might, by mutual agreement, include some formal retraining or re-skilling.
- Sick leave for the investigation of specific health problems.

No informal exclusions, for example 'gardening leave', will be permitted through this procedure.

NHSR has produced a template for documenting any case where exclusion is considered, to ensure the rationale for an exclusion is documented at the outset and at regular review points:
https://resolution.nhs.uk/wp-content/uploads/2022/04/Recording-template-for-formal-exclusion-of-a-practitioner-FINAL.docx

See NHSR exclusion guidance and **Appendix Ten** for PPA advice on considering exclusion.

5.2.3 Informing other organisations where the practitioner practises

Where there is concern that the practitioner may be a danger to patients, the RO/ROAG will inform such other organisations, including the private sector, of any restriction on practice or exclusion and provide a summary of the underlying reasons, which is shared with the practitioner. If details of other employers are not readily available from Appraisal or Job Plan records, the practitioner will be required to provide them and will be advised that failure to do so may result in further disciplinary action or referral to the GMC/GDC. Where restrictions have been placed on practice, the practitioner must agree not to undertake any work in that area of practice with any other employer. If, having spoken to the practitioner, the RO/ROAG believes a practitioner is practising in breach of an undertaking not to do so, they will contact the GMC ELA/GDC.

5.2.4 Immediate time limited exclusion

This may be necessary where:

- there has been a critical incident and serious allegations have been made
- there has been a breakdown in relationships between the practitioner and the rest of the team
- the presence of the practitioner is likely to hinder the investigation

This period will be used to carry out a preliminary situation analysis, to contact PPA for advice and to convene a case conference. The manager making the exclusion will explain why the exclusion is being made in broad terms and agree a date, up to a maximum of 2 weeks later, when the practitioner should return to the workplace for a further meeting. The manager will advise the practitioner of their rights, including the right to be represented.

5.2.5 Informing the practitioner of exclusion

- The RO/ROAG will inform the practitioner of the exclusion.
- Arrangements will be made for a witness to be present, where practical, bearing in mind the need to maintain the practitioner's confidentiality.
- The practitioner will be given the opportunity to have a companion/ representative present.
- The nature of the allegations or areas of concern will be conveyed to the practitioner and the reason(s) why formal exclusion is regarded as the only way to deal with the case.
- The practitioner will be given the opportunity to state their case and propose alternatives to exclusion (for example, further training, sick leave, referral to PPA with voluntary restriction).
- Wherever possible, the practitioner will be informed face to face and, where this is not possible, by telephone, and in both cases followed up in writing.
- **The letter to the practitioner will state**
    - the effective date and time of the exclusion
    - the duration (up to 4 weeks) of the exclusion
    - the content of the allegations
    - the terms of the exclusion and whether it includes exclusion from the premises (see **5.2.1**)
    - the right to be accompanied (see **5.1.5**)
    - the need to remain available for work (see **5.2.9**)
    - a full investigation or other action will follow.

NHSR has produced a template letter for employers to use when communicating with the practitioner to help ensure all the relevant information is included: https://resolution.nhs.uk/wp-content/uploads/2022/04/Template-letter-for-exclusions-FINAL.docx

- The practitioner and their companion will be advised that they may make representations about exclusion to the designated board member at any time after receipt of the letter confirming the exclusion.
- Where possible, the RO/ROAG will ensure that arrangements are made to allow the practitioner to keep in contact with colleagues on professional

developments and take part in CPD and clinical audit activities with the same level of support as other practitioners. Consideration will be given to identifying a mentor for this purpose.

5.2.6 Managing the exclusion process

Once a decision has been made to exclude a practitioner, the Case Manager's role includes the management of the exclusion process. The CEO has overall responsibility for ensuring the exclusion is properly managed and will be responsible for ensuring the Trust Board is informed of the exclusion at the earliest opportunity. When requested, a detailed report is provided by the Case Investigator to the Designated Board Member who will be responsible for monitoring the situation until the exclusion has been lifted to ensure the process is fair and not unduly prolonged.

5.2.7 Reviewing an exclusion/restriction on practice

- The exclusion will be for the minimum period necessary and for no more than 4 weeks at a time.
- **Before the end of the 4-week period,** the justification for extending the exclusion will be reviewed by the Case Manager. Careful consideration will be given as to whether the interests of patients, other staff, the practitioner, and / or the needs of the investigative process continue to necessitate the exclusion.
- Full consideration will be given to the option of the practitioner returning to limited or alternative duties where practicable. If a return to work is considered inappropriate, the exclusion is extended for another 4-week period. The Case Manager will:
    - Provide a brief report to the CEO and Trust Board.
    - Share the report with the practitioner.
    - Consider contacting PPA.
    - Send a written extension to the practitioner or lift exclusion
- The same time frames as those outlined to review exclusions will be applied to reviewing restrictions on practice, although the requirement for reporting to the Trust Board does not apply in these circumstances.
- As Board members may be required to sit on any future disciplinary or appeal panels, the information provided will be sufficient only to assure the Board that procedures are being followed. Only the Designated Board Member will be involved to any significant degree in reviewing the exclusion.
- If the exclusion is not actively reviewed, the exclusion will lapse and the practitioner will be entitled to return to work at the end of the 4-week period.
- Representations may be made by the practitioner or their representatives (e.g. their medical defence society) to the Designated Board Member regarding the exclusion or investigation of a case.
- If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (e.g. 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. During such a prolonged period the principle of 4-week renewability will continue.

If a practitioner has been excluded for three 4-week periods:

- Alternatives such as supervision/restrictions should be re-considered.
- PPA must be consulted.
- A report will be sent by the Case Manager to the Designated Board Member and Board outlining the reasons for the continued exclusion, why restrictions on practice would not be a suitable alternative and what steps are being taken to conclude the exclusion at the earliest opportunity. A timetable will be provided for concluding the investigation if this is still ongoing.
- The report will be shared with the practitioner.
- A written extension letter will be sent to the practitioner if the exclusion is not lifted.

If the exclusion continues over 6 months:

- Alternatives such as supervision/restrictions should be re-considered.
- PPA must be consulted for advice to ensure the case is proceeding at an appropriate pace and in the most effective manner.
- A further report will be sent by the Case Manager to the Designated Board Member and Board, giving the reason for continuing the exclusion and anticipated timescale for completing the process.
- The report will be shared with the practitioner.
- A written extension letter will be sent to the practitioner if the exclusion is not lifted.
- Normally exclusions will be for a maximum of 6 months, except in cases involving criminal investigations where the Trust and PPA will actively review the case at least every 6 months.

5.2.8 Availability for work

Practitioners will be given 24 hours' notice to return to work and must remain available for work during their normal contracted hours. The practitioner must inform the RO/ROAG of any other organisation(s) with whom they undertake either voluntary or paid work and seek their consent to continue to undertake such work. The practitioner will be reminded of these contractual obligations.

5.2.9 Salary payment during periods of exclusion

Practitioners will receive full pay during periods of exclusion except in exceptional circumstances when the RO/ROAG may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

5.2.10 Lifting an exclusion

When it is decided that exclusion should come to an end, appropriate formal arrangements must be made for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged. If changes are to be made or restrictions to practice are to continue, these must be clearly specified. Any monitoring arrangements, for example, behavioural contracts to ensure patient safety, must also be clearly specified. Wherever possible the practitioner will be informed face to face but, where this is not possible, by video link or telephone, and in all cases followed up in writing.

See **Appendix Eleven** Return to practice planning

5.3 Conduct Hearings and Disciplinary Procedures

5.3.1 Categories of misconduct

Breaches of rules, which are regarded as misconduct, will generally fall into one of the following categories:

- a refusal to comply with reasonable management requirements
- an infringement of disciplinary rules, including conduct which contravenes the standard of professional behaviour required by practitioners by the GMC/GDC.
- Committing criminal offences outside of work which may, in some circumstances, amount to misconduct.
- Wilful, careless, inappropriate, or unethical behaviour likely to compromise standards of care or patient safety or create serious dysfunction to the effective running of a service.
- Failure to fulfil contractual obligations may also constitute misconduct, for example regular non-attendance at clinics, ward rounds or multidisciplinary team meetings, or not taking part in clinical governance activities. Failing to give proper support to other members of staff including practitioners in training may be considered in this category.

5.3.2 Dealing with misconduct of practitioners

All issues regarding the misconduct of practitioners will be dealt with in accordance with the Trust Disciplinary Policy. Advice will be sought from PPA, particularly in cases of professional misconduct.

5.3.3 Obtaining independent professional advice

Where the alleged misconduct relates to matters of a professional nature or where the investigation identifies issues of professional conduct, the Case Investigator will obtain appropriate independent professional advice.

5.3.4 Panel hearing composition

If the case proceeds to a hearing, the diversity of the panel will be considered, and the panel will include a medically qualified member who is not in the employment of the Trust.

5.3.5 Support for practitioners at hearings

These procedures are not intended to operate in a legalistic manner. Practitioners may be accompanied by a friend, partner/spouse, work colleague, trade union/defence organisation representative at meetings and hearings referred to in this policy. A practitioner may be accompanied at any hearing by a person who is legally qualified but not acting in a legal capacity. Similarly, in certain circumstances, the Trust may elect to have a legally qualified person to present the management case or chair a Panel, although not acting in a legal capacity. Panels may also have support from a legally qualified person.

5.3.6 Confidentiality

This will be always maintained. No press notice will be issued. The name of the practitioner involved in any investigation or hearing into disciplinary matters will not be released; the Trust will confirm only that an investigation or disciplinary hearing is underway. Any data released will be compliant with the Data Protection Act. The Trust will inform the practitioner or their representative if they are approached by the media and any such communications will be channelled through the Director of Communications.

5.3.7 Dismissals

As a general rule, no doctor will be dismissed for a first offence, unless it is one of gross misconduct. If a practitioner considers that the case has been wrongly classified as misconduct, they, or their representative, is entitled to use the Grievance Procedure. Alternatively, or in addition, representations can be made to the Designated Board Member.

5.4 Allegations of Criminal Acts

5.4.1 Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The trust investigation will proceed only in respect of those aspects of the case not directly related to the police investigation. The Trust will consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service will be contacted.

5.4.2 Doctors will be reminded they must inform the GMC without delay if they are charged with a criminal offence (section 75a, ***Good Medical Practice***[7]).

5.4.3 Some criminal offences, if proven, could render a doctor unsuitable for employment, for example, if the offence brings the Trust into disrepute. In all cases, having considered the facts, the Trust will consult the GMC ELA and PPA and consider whether the practitioner poses a risk to patients or colleagues and whether their conduct warrants an investigation and/or the exclusion of the practitioner. The Trust will give serious consideration as to whether the practitioner can continue in their job once criminal charges have been made. The Trust will consider whether the offence, if proven, is one that makes the practitioner unsuitable for their type of work and whether, pending the trial, they can continue in their present job, be allocated to other duties, or be excluded from work, depending on the nature of the offence. The practitioner will be advised of the reasons for taking such action.

5.4.4 If a practitioner is acquitted, but the Trust feels there is sufficient evidence to suggest a potential danger to patients, 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. The police will be advised that any evidence they provide that is used in the Trust's case will be made available to the doctor concerned. Where charges are dropped, whilst it is possible that the practitioner will be re-instated, the same considerations will need to be applied.

Discretionary referral to the Disclosure Barring Service will be considered as per GMC guidance
DC4502 Guidance on referral to the Disclosure Barring Service.pdf 57788495.pdf (gmc-uk.org)

5.5 Agreeing Terms for Settlement on Termination of Employment

5.5.1 Terms of settlement may be agreed with a practitioner in some instances if their employment is to be terminated. Such an agreement will be made in accordance with the following good practice principles:

- Settlement agreements will not be to the detriment of patient safety.
- It is not acceptable to agree any settlement that precludes appropriate investigation or referral to the GMC/GDC.

- Payment will not normally be made when employment is terminated on disciplinary grounds or following resignation.
- Expenditure on termination payments must represent value for money and the Trust should be able to defend the settlement on the basis that it could conclude the matter more cost effectively than other options. A clear record will be kept setting out how the Trust has considered all relevant factors including legal advice. The audit trails will also show that the matter has been considered and approved by the Nomination & Remuneration Committee and the Trust Board. The process must also be able to stand up to district auditor and public scrutiny.
- Offers of compensation as an inducement to secure the voluntary resignation of a practitioner will not be used as an alternative to the disciplinary process.
- Future job references for the practitioner will be accurate, realistic, and comprehensive and, under no circumstances, misleading.

5.5.2 The details of a termination settlement 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, but it must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an open reference.

5.6 Dealing with issues of Capability

5.6.1 A capability issue is described as consistently poor performance or the clear failure by an individual practitioner to deliver an adequate standard of care through lack of knowledge, competence, or ability. Concerns about the capability of a doctor may arise from a single incident or a series of events and may come to light because of poor clinical outcomes.

5.6.2 Matters which may fall under the capability procedure 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
- inappropriate delegation of clinical responsibility
- inadequate supervision of delegated clinical tasks
- ineffective clinical team working skills

5.6.3 Case Managers will be advised to make use of the **Incident Decision Tree** NHS_0932_JC_Guide_A3 (england.nhs.uk) which has been developed by the NHSEI to help managers determine a fair and consistent course of action with staff following a patient safety incident. The aim is to facilitate the development of an open and fair culture, which encourages doctors and other NHS staff to report adverse incidents and near misses in a climate free from fear of personal reprimand, where the sharing of experience helps others to learn lessons and in turn improve patient safety. It aims to ensure staff are not routinely blamed when errors occur due to system failures.

5.6.4 Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. PPA has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and should be consulted. PPA resources relating to practitioner performance can be found at https://resolution.nhs.uk/resourceservices/practitioner-performance-advice/.

5.6.5 In cases relating to the capability of a practitioner, consideration will be given to whether the problem can be resolved by agreeing an action plan with them. Advice will be sought from PPA. If a workable remedy cannot be determined, the Case Manager will seek to agree with the doctor to formally refer the case to PPA so that the problem can be assessed in more depth and advice provided. If the concerns about capability cannot be resolved, the matter must be referred to PPA before it is considered by a capability panel.

5.6.6 Cases involving both conduct and capability issues are complex and difficult to manage. If a case covers more than one category of problem, they will normally be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. The Trust will determine the most appropriate course of action following consultation with PPA, the HR department or other employment law specialist.

5.6.7 Capability may be affected by ill health. The procedure for dealing with health matters is detailed in Section **5.8**.

5.7 Capability Process

5.7.1 Pre-hearing

5.7.1.1 When the investigation report is received from the Case Investigator, the Case Manager will give the practitioner the opportunity to comment in writing on the factual content of the report. The practitioner response must normally be submitted within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example, complex changes or annual leave, the deadline for comments can be extended.

5.7.1.2 The Case Manager will decide what further action is necessary, considering the findings of the report, any comments the practitioner has made, and the advice of PPA. The Case Manager will urgently consider whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If such action is not practicable, the matter will be referred to PPA for consideration as to whether an assessment of the practitioner should be carried out. The Case Manager will inform the practitioner concerned of the decision, normally within 10working days of receiving the practitioner's comments. PPA will normally assist the Trust in drawing up an action plan designed to enable the practitioner to remedy any lack of capability identified during the assessment. The action plan must be agreed by the Trust and the

practitioner, and the Trust must then facilitate the agreed action plan.

5.7.1.3 The interrelationship between NHS Resolution and the operation of MHPS

It is mandatory for a Trust (once local action has been ruled out) to refer the matter to PPA for it to consider whether an assessment should be carried out. However, there is no obligation on PPA to carry out an assessment and no obligation to aid in drawing up an action plan.

The Trust may commence an MHPS procedure when considering a practitioner's capability where:

- a PPA assessment has not been agreed (or is not practicable); or
- a PPA has completed an assessment, but an action plan cannot be agreed.

A Trust cannot reject a PPA action plan to move to a capability hearing. However, where an employee and a Trust are in dispute over an action plan, the appropriate forum for resolving that dispute is a capability panel, convened under MHPS. See **https://www.bevanbrittan.com/insights/articles/2014/clarityonmhpscapabilityproceedings/**

5.7.1.4 There may be occasions when a case has been considered by PPA and 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 decide, 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.

5.7.1.5 Should the Practitioner not agree to the case being referred to PPA, a panel hearing will normally be arranged.

Failure to co-operate with a referral to PPA will be viewed as a lack of willingness on the part of the practitioner to work with the Trust to resolve performance difficulties which may limit the options available and could necessitate disciplinary action and consideration of referral to the GMC/GDC.

For a further description of the role and involvement of PPA following Local Investigation see **Appendix Twelve.**

5.7.2 Capability Hearing

5.7.2.1 Capability hearings will normally be chaired by an Executive Director of the Trust. However, in certain cases the Trust may decide to appoint a legally qualified Chair in the interests of both parties. The panel will comprise a total of 3 people, including 2 members of the Trust Board, or other senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel will be a medical practitioner not employed by the Trust. No member of the panel or advisers to the

panel will have been previously involved in the investigation. In the case of a clinical academic(s), a further panel member may be appointed in accordance with any protocol agreed between the Trust and the relevant University.

5.7.2.2 The panel and the Practitioner will be advised by:

- a senior Human Resource Manager
- a senior clinician from the same or similar clinical specialty as the practitioner concerned but from another NHS employer
- a representative of a university if provided for in any protocol

5.7.2.3 The Case Manager will notify the practitioner in writing of the decision to arrange a capability hearing. This notification will be made at least 20 working days before the hearing and will include details of the allegations and the arrangements for proceeding, including the practitioner's right to be accompanied, and copies of any documentation and/or evidence that will be made available to the capability panel.

5.7.2.4 The Trust will determine the membership of the panel. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification giving reasons for the objection. In such cases the situation will be reviewed, and reasonable measures taken to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing until the matter is resolved. The practitioner will be provided with the reasons for reaching the decision in writing before the hearing can take place.

5.7.2.5 All parties will exchange any documentation on which they wish to rely in the proceeding, including witness statements, 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.

5.7.2.6 If either party requests a postponement of the hearing, the Case Manager will be 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 normally 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.

5.7.2.7 If the practitioner's ill health prevents the hearing taking place the Trust will implement their usual absence procedures and involve OH as necessary.

5.7.2.8 Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing. The Chairman will invite witnesses to attend following representations from either side contesting a witness statement which is to be relied upon in the hearing. The Chairman will not require anyone other than an employee 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.

5.7.2.9 If a witness is required to attend the hearing chooses to be accompanied, the person accompanying them will not be able to participate in the hearing.

5.7.2.10 Representation at capability hearings The hearing is not a court of law and will not be conducted in a legalistic or excessively formal manner. The practitioner will be given every reasonable opportunity to present their case and they may be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organisation. Such representation may be legally qualified, but they will not be representing the practitioner 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.

5.7.2.11 In circumstances where the practitioner chooses to be accompanied at internal hearings by a legal representative the Trust reserves the right to engage a legally qualified person to present the management case at the hearing.

5.7.3 Conduct of the Capability Hearing

5.7.3.1 The hearing will be conducted as follows: -

- The following members will all be present at all times during the hearing:
  - The panel and its advisers
  - The practitioner
  - The practitioner's companion/representative
  - The Case Manager
- Witnesses will be admitted only to give their evidence and answer questions.
- The Chair of the panel will be responsible for the proper conduct of the proceedings. The Chair will introduce all persons present and announce which witnesses are available to attend the hearing.

5.7.3.2 The same procedure will be used for all witnesses attending the hearing and will reflect the following:

- The witness to confirm any written statement and give any supplementary evidence
- The side which called 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 raise new evidence

5.7.3.3 The order of presentations will be:

- The Case Manager presents the management case, including calling any witnesses. The procedure in **5.7.3** will be followed for each witness in turn.
- The Chair will 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 will present the practitioner's case, calling any witnesses in accordance with the above procedure.
- The Chair will 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 will invite the Case Manager to make a brief closing statement summarising the key points of the case.
- The Chair will 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 ground for mitigation.
- The panel will then retire to consider its decision.

5.7.3.4 Decision

The panel has the power to make a range of decisions including:

- 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 - *this will stay on the practitioner's record for 6 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 – *this will stay on the practitioner's record for 1 year.*
- Final 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 – *this will stay on the practitioner's record for 1 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 e.g. regarding the systems and procedures of the Trust.

5.7.4.5 A record of oral agreements and written warnings will be kept on the practitioner's personal HR file but will be removed following the specified period. The RO will retain records of fitness to practice actions in compliance with GMC guidelines - GMC Council 180107 (gmc-uk.org).

5.7.4.6 The decision of the panel will be communicated to all parties as soon as possible and normally within 5 working days of the hearing. Given the potential complexities of issues under deliberation it is unlikely that a decision will be reached on the day of the hearing.

5.7.4.7 The decision will be confirmed in writing to the practitioner, together with the reasons for the decision, clarification of the right of appeal, and notification of any intent to make a referral to the GMC/ GDC or other external/professional body.

5.8 Appeals Procedure

5.8.1 The appeals procedure provides a mechanism for practitioners who disagree

with the outcome of a capability hearing to have the opportunity to have the case reviewed. The role of the appeal panel will be to establish whether:

- the Trust's procedures were followed
- the panel acted fairly and reasonably based on a fair and thorough investigation of the issue
- the investigation or assessment provided sufficient evidence on which to base the decision
- the decision was fair and reasonable in the circumstances and commensurate with the evidence heard.

5.8.2 The appeal panel can hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing, but they will not rehear the entire case.

5.8.3 A dismissed practitioner will in all cases be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

5.8.4 The appeal panel has the power to confirm or vary the decision made at a capability hearing, or order that the case is reheard. Where it is clear during an appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully reheard, the Chair of the panel has the power to instruct a new capability hearing.

5.8.5 If the outcome of a capability hearing is dismissal, the practitioner will not be paid from the date of termination of employment during the period of appeal. If the appeal is upheld, the practitioner will be reinstated and pay will be backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner will 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.

5.8.6 Appeal Panel

The appeal panel will consist of 3 members who will not have had any previous direct involvement in the matters that are the subject of the appeal. The members will be:

- An independent member (trained in legal aspects of appeals) from an approved pool to be administered by NHS Employers. (See **Appendix Thirteen)**
- The Chair, or other non-executive director of the Trust who has had appropriate training for hearing an appeal.
- A medically qualified member not employed by the Trust, who has had appropriate training for hearing an appeal.
- In the case of clinical academics, a further panel member may be appointed in accordance with any protocol agreed between the Trust and the University.

5.8.7 The appeal panel can call on others to provide specialist advice. This will

normally include:

- A Consultant from the same specialty or subspecialty as the appellant but from another NHS employer
- A senior Human Resources specialist

5.8.8 If for any reason the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer at the same grade as the practitioner in question will be asked to provide advice.

5.8.9 Every effort will be made to ensure that the panel members are acceptable to the appellant. If agreement on the constitution of the panel cannot be reached, the appellant's objections will be carefully noted.

5.8.10 Appeals will be heard as soon as possible after the original capability hearing. Arrangements for Appeal Panels will be made by the HR Department, in accordance with the following timetable:

- The practitioner will be required to submit a written appeal statement to the Chief People Officer within 25 working days of the confirmation of the original decision.
- The hearing will take place within 25 working days of the date of receipt of the appeal statement.
- The decision of the appeal hearing will be reported to the practitioner within 5 working days of the conclusion of the hearing.

5.8.11 The timetable will be agreed between the Trust and the appellant and can be varied only by mutual agreement. The Case Manager will be informed and will be responsible for ensuring that extensions are necessary and kept to a minimum.

5.8.12 Powers of the appeal panel

The panel has the right to call witnesses but must notify the Trust representatives, the practitioner, and their representative at least 10 working days in advance of the hearing and provide them with a written statement from any such witnesses at the same time. In such cases, both parties will have the reasons for calling witnesses explained to them and they will be given the opportunity to respond to the statements provided. Exceptionally, where during the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, it will have the power to adjourn the hearing to allow for a written statement to be obtained from that witness and made available to both parties before the hearing reassembles.

If, during the hearing, the appeal panel determines that new evidence needs to be presented, it will 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, based on the new evidence, by a capability hearing panel.

5.8.13 Conduct of appeal hearing

- All parties will have all documents, including witness statements, from the previous capability hearing together with any new evidence.
- The practitioner may be represented in the process by a friend, partners or spouse, colleague or a representative who may be from, or retained by, a trade union or defence organisation. Such a representative may be legally qualified, but they will not be representing the practitioner formally 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 will briefly sum up. At this stage, no new information can be introduced but the practitioner or their companion can make a statement in mitigation.
- After receiving the views of both parties, the panel will consider and make its decision in private. The practitioner and Case Manager will be notified of the decision in writing within 5 working days of the conclusion of the hearing. The reasons for the decision will normally be provided also. The decision of the appeal panel will be final and binding. There will be no correspondence on the merits of the case or on the decision of the panel except and unless clarification is required on what has been decided, in which case this should be sought in writing from the Chairman of the appeal panel.
- Records will be kept, including a report detailing the capability issues, the practitioners defence or mitigation, the action taken and the reasons for the action. The records will be confidential and retained in accordance with the procedure and the Data Protection Act 1998 and will 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.

5.9 Termination of Employment with Performance Issue Unresolved

5.9.1 Where a practitioner leaves employment before disciplinary procedures have been completed, the investigation will be taken to a conclusion in all cases and capability proceedings must be completed wherever possible whatever the personal circumstances of the practitioner concerned.

5.9.2 In such cases, every effort will be made to ensure the practitioner remains involved in the process. If contact with them 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. A judgement will be made, 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, including requesting the issue of an HPAN alert letter and referral to the GMC/ GDC, the police, or the Protection of Children Act list (held by the Department of Education and Skills).

The RO will share the outcome via a Medical Transfer of Information (MPIT) form with the doctor's new RO.

https://www.england.nhs.uk/professional-standards/medical-revalidation/ro/info-docs/mpit-form

5.9.3 If an excluded employee, or an employee facing capability proceedings, becomes ill, they will be subject to the Trust's Sickness Management Policy which will take precedence over the capability procedure. Reasonable steps will be taken to give the practitioner time to recover and attend any hearings. Where the illness exceeds 4 weeks, the Case Manager will refer them to the OH service. The OH service will advise the Case Manager on the expected duration of the illness and any consequences it may have for the capability process and will also advise on the practitioner's capacity for future work. Retirement on ill health grounds may then be a consideration but, if the employment is terminated on health grounds, the investigation will still be taken to a conclusion and a judgement formed as to whether the allegations are upheld.

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

5.10 Handling Concerns About a Practitioners Health

5.10.1 It is acknowledged that a variety of health problems can have an impact on a practitioner's clinical performance. Such conditions may arise spontaneously or be a consequence of workplace factors. Wherever possible, and consistent with public protection, such practitioners will be treated, rehabilitated, or re-trained with the aim of keeping them in employment.

5.10.2 Examples of action that may be taken include:

- Sick leave with frequent contact maintained
- Removing the practitioner from certain duties
- Re-assigning the practitioner to a different area of work
- Arranging re-training or adjustments to the working environment, with appropriate advice from PPA, under the reasonable adjustment provision in the Disability Discrimination Act 1995 or Equality Act 2010.
- Arranging random drug/alcohol testing at work for the practitioner if deemed appropriate

5.10.3 Where an incident points to a problem with a practitioner's health, the incident may need to be investigated to determine if there is a health problem. If the investigation report recommends the involvement of the OH Service, the nominated manager must immediately refer the practitioner to the OH Physician and PPA will be approached for advice.

5.10.4 The OH Physician will agree a course of action with the practitioner and send their recommendations to the RO/ROAG who will meet with the Case Manager (where appropriate), the Practitioner and a case worker from OH to agree a timetable of action and rehabilitation, where appropriate. The practitioner may wish to bring a support companion to the meeting, who could be a family member, a colleague or a trade union or defence association representative. Confidentiality will be always maintained

by all parties.

5.10.5 The practitioner will be always supported by the Trust and OH to ensure they are offered every reasonable resource to return to practice where appropriate.

5.10.6 Examples of reasonable adjustment include:

- Adjustments to the premises
- Re-allocation of some duties to another person
- Transfer of the practitioner to an existing vacancy
- Altering the practitioner's working hours or pattern of work
- Assigning the practitioner to a different workplace
- Allowing absence for rehabilitation, assessment, and treatment
- Providing additional training or retraining
- Acquiring or modifying equipment
- Modifying procedures for testing or assessment
- Establish mentoring arrangements

5.10.7 In some cases, retirement due to ill health may be necessary and this will be approached in a reasonable and considerate manner and in line with NHS Pensions Agency advice. Any co-existing issues relating to conduct and capability will however be resolved using the procedures outlined above.

5.10.8 If a practitioner's ill health makes them a danger to patients and they do not recognise this or are not prepared to co-operate with measures to protect patients, the case will be discussed with PPA and the GMC ELA, exclusion from work will be considered and a Fitness to Practice referral will be made to the GMC/ GDC, irrespective of whether they have retired on health grounds.

5.10.9 Where there is impairment of performance solely due to ill health, disciplinary procedures will only be considered in the most exceptional circumstances, for example, if the practitioner refuses to co-operate with the Trust to resolve the underlying situation.

5.10.10 Where a practitioner who is the subject of disciplinary proceedings puts forward a case on health grounds, the disciplinary proceedings will be delayed, modified, or terminated. In such cases the practitioner will be referred to the OH Service for assessment. Unreasonable refusal to accept a referral to OH, or to co operate with the OH Service under these circumstances, will give separate grounds for pursuing disciplinary action.

5.10.11 In other circumstances, practitioners will be subject to the Trust's **Sickness Absence Management** procedures.

5.11 Return to Practice

5.11.1 The Trust has a responsibility to ensure that an appropriate process is in place to support a practitioner's return to practice following an absence under this Policy. Each practitioner will have different needs reflecting their experiences and

circumstances. Even the shortest of absences may affect confidence and skill levels.

5.11.2 It is important that the practitioner and the Trust prepare for any predictable absences from practice and together ensure there is a supportive plan in place for the practitioner's return, using the checklist and recommendations in **Appendix Eleven.** Alternatively, there should be an evaluation of the practitioner's needs prior to, or on return to work.

5.11.3 The responsibility on behalf of the Trust for working with the Practitioner to undertake this assessment will lie with the CMO/Deputy MD/Divisional MD or CD as appropriate.

5.11.4 If at any point evidence arises that suggests patient safety is being compromised or may be compromised, the appropriate authorities must be informed, and appropriate action taken.

5.11.5 The following will need to be identified in formulating a return to practice action plan:

- The practitioner's learning needs
- How the practitioner has successfully learnt in the past
- What new learning is necessary to help improve patient care?
- How this learning will fit in to the practitioner's job plan
- How and when the plan will be assessed and whether the learning needs have been met
- How learning will be funded

5.11.6 Possible actions to assist the practitioner's safe return to practice may include:

- Identification of plans for education on return to practice or Continuous Professional Development, such as specific updates, that can be undertaken whilst away, or immediately on return.
- Ensuring that initial patient lists are straightforward, and that additional support is available
- Ensuring enough time is allowed on return for discussions with colleagues and managers
- Periods of observation of the practitioner
- Supernumerary arrangements for a period if necessary
- Formal or informal mentoring
- Flexible hours or other flexible working arrangements

5.11.7 An action plan will be agreed between the practitioner and a nominated individual who will review progress on a regular basis and provide an update to the RO/ROAG on request.

5.11.8 The practitioner should arrange an appraisal **6 months** after return from the absence.

Pre and Post absence checklists are included in **Appendix Eleven**.

6 Exceptions

This Policy applies to all medical and dental staff employed by the Trust and incorporates the required processes when issues arise with practitioners not directly employed by the Trust e.g. Trainees, Clinical Academics and those employed on honorary contracts.

7 Training

- Training for Case Managers
- Training for Case Investigators
- Awareness sessions for managers of medical and dental staff

8 Monitoring document effectiveness

A high level summary of the MHPS cases will be sent to the Trust Board on a monthly basis highlighting Key Areas of Concern.

9 Relevant regulations, standards and references

1. Maintaining High Professional Standards in the Modern NHS (Department of Health, 2003) http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072773

2. The Medical Profession (Responsible Officers) Regulations 2010 https://www.legislation.gov.uk/uksi/2010/2841/introduction/made

3. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/391/contents/made

4. NHS England 2019 A practical guide for responding to concerns about medical practice *https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/*

5. GMC principles of a good investigation. https://www.gmc-uk.org/-/media/documents/dc11437-principles-of-a-good-investigation_pdf-75546780.pdf

6. Trainees Requiring Extra Support (TRES) Referral Guide - Health Education England https://nwpgmd.nhs.uk/sites/default/files/TRES%20Referral%20Pack%20-%20Nov%202018.pdf

7. Good Medical Practice – GMC Good medical practice-english (gmc-uk.org)

8. Healthcare Professional Alert Notice Directions (Department of Health) 2006 https://resolution.nhs.uk/services/practitioner-performance-advice/hpans

9. Learning lessons to improve our people practices, NHSE May 2019

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10. NHSR resources relating to practitioner performance https://resolution.nhs.uk/resource-services/practitioner-performance-advice/.

11. NHSR exclusion guidance

12. GMC Thresholds https://www.gmc-uk.org/-/media/documents/dc4528-guidance-gmc-thresholds_pdf-48163325.pdf

13. NHS England » A just culture guide NHS_0932_JC_Guide_A3 (england.nhs.uk) NHS England 2021

14. **https://www.bevanbrittan.com/insights/articles/2014/clarityonmhpscapabilityproceedings/**

10 Equality, diversity and human right statement

The Trust is committed to an enviroment that promotes equality and embraces diversity in its performance both as a service provider and employer. It will adhere to legal and performance requirements and will mainstream Equality, Diversity and Human Rights principles through its policies, procedures, service development and engagement processes.This document should be implemented with due regard to the commitment.

11 Appendix

Appendix 1: Equality Impact Assessment

- The below tool must be completed at the start of any new or existing policy, procedure, or guideline development or review. **N.B.** For ease, all documents will be referred to as 'Policy*'. The EIA should be used to inform the design of the new policy and reviewed right up until the policy is approved and not completed simply as an audit of the final Policy itself.

- EIAs must be sent for review prior to the policy* being sent to committee for approval. Any changes made at committee after an EIA has been sign off must result in the EIA being updated to reflect these changes. Policies will not be published without a completed and quality reviewed EqIA.

1. Possible Negative Impacts			
Protected Characteristic	**Possible Impact**	**Action/Mitigation**	
Age	No		
Disability	No		
Ethnicity	No		
Gender	No		
Marriage/Civil Partnership	No		
Pregnancy/Maternity	No		
Religion and Belief	No		
Sexual Orientation	No		
Trans	No		
Other Under Served Communities (including Carers, Low Income, Veterans)	No		

2. Possible Opportunity for Positive Impacts		
Protected Characteristic	**Possible Impact**	**Action/Mitigation**
Age	No	
Disability	No	
Ethnicity	No	
Gender	No	
Marriage/Civil Partnership	No	
Pregnancy/Maternity	No	
Religion and Belief	No	
Sexual Orientation	No	
Trans	No	

Other Under Served Communities (Including Carers, Low Income, Veterans)	No	

3. Combined Action Plan

Action (List all actions and mitigation below)	**Due Date**	**Lead** (Name and Job Role)	**From Negative or Positive Impact?**

4. Information Consulted and Evidence Base (Including any consultation)

Protected Characteristic	**Name of Source**	**Summary of Areas Covered**	**Web link/contact info**
Age			
Disability			
Ethnicity			
Gender			
Marriage/Civil Partnership			
Pregnancy/Maternity			
Religion & Belief			
Sexual Orientation			
Trans			
Other Under Served Communities (Including Carers, Low Income, Veterans)			

5. EIA Update Log

Date of Update	**Author of Update**	**Change Made**

6. Have all of the negative impacts you have considered been fully mitigated or resolved? NA

7. Please explain how you have considered the duties under the accessible information standard if your document relates to patients? NA

8. Equality Impact ~~A~~ssessment completed and signed off
Name: Eileen Marks **Date: 14th February 2023**

Appendix 2: Roles and responsibilities

This policy has been updated to include the statutory role of the Responsible Officer (RO) of the Trust and to reflect changes in roles and responsibilities in LUHFT, a large organisation where some tasks previously performed by the Medical Director, Chief Executive Officer (CEO) or Chief People Officer may now be delegated to appropriately trained senior staff as outlined below.

Every doctor is expected to practise in accordance with the principles and values set out in ***Good Medical Practice***[7]. Practitioners have a professional duty to maintain their fitness to practise; this includes a duty to be proactive about raising concerns about their practice, to acknowledge a concern if one is raised, and to engage constructively with steps to address this. Practitioners have a duty to comply with the Trust's clinical governance systems put in place to protect and improve patient care, and to report concerns about the practice of colleagues, or about systemic or organisational barriers to providing safe care to patients.

Role	**Responsibility**
Responsible Officer	The Responsible Officer (RO) has statutory duties in relation to doctors with whom they have a prescribed connection. The RO is appointed by the Trust, which in turn has a duty to support the RO. The RO statutory duties include ensuring the provision of processes to: • monitor a doctor's performance • identify and respond to concerns about a doctor's performance • verify a doctor's suitability for the work they are engaged to do • ensure robust pre-employment checks for doctors The RO has a duty to refer concerns to the GMC when necessary, and to monitor compliance with GMC conditions or undertakings. From the ***Medical Profession (Responsible Officers) Regulations 2010***
Responsible Officer Advisory Group	While statutory responsibilities in relation to the RO regulations rest with the RO, their decisions are assisted by frequent discussions with members of the Responsible Officer Advisory Group (ROAG). The ROAG is chaired by the RO, MD or deputy and includes: • Deputy Medical Directors • AMD for Professional Standards • Chief People Officer • Deputy Chief People Officer

	Persons with governance responsibility for the doctor, such as CDs, will also be involved in the decision-making process if appropriate. This range of perspectives provides objectivity and helps minimise risk. The role of the RO is underpinned by the Trust's governance structure and, while the RO retains the statutory duties set out above, some of the RO duties may be performed by other members of the ROAG or by those with appropriately delegated responsibility for the governance of a practitioner's practice, for example, Divisional Medical Directors (DMDs) or CDs. Throughout this document, the abbreviation **RO/ROAG** is used to reflect this arrangement. See **Appendix Twelve** for the Terms of Reference for the Responsible Officer Advisory Group (ROAG).
Chief Executive Officer	The Chief Executive Officer (CEO) has overall responsibility for ensuring cases are properly managed and appropriate exclusion procedures are followed. They must be informed of all exclusions and serious concerns.
Chairman	It is the Chairman's responsibility to designate a Non-Executive Director (Designated Board Member) to oversee case investigations. This role is usually delegated to the Trust's Corporate Secretary.
Chief Medical Officer	As a member of the ROAG, the CMO is closely involved in the management of concerns and must be informed of all serious concerns.
Designated Board Member (Non-Executive Director)	The Designated Board Member is assigned to a case investigation by the Chairman/Trust's Corporate Secretary and is responsible for: • overseeing the case during the investigation process and ensuring momentum is maintained. • receiving reports from the Case Manager regarding practitioners who have been excluded, or whose practice has been restricted, and reviewing any continued exclusion from work.

	• considering any representations from the practitioner regarding the investigation or exclusion. • ensuring that time frames for investigation or exclusion are consistent with Human Rights principles. ensuring fairness so all practitioners from any background are treated equitably and consistently.
Trust Board	The Trust Board has a responsibility to ensure correct procedures are being followed, particularly regarding the exclusion of practitioners. To this end, the Board will: • receive a summary of the progress of each exclusion case at the end of each four-week period of exclusion, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to resolve the situation as quickly as possible. receive a monthly summary of all exclusions including the duration and the number of times each has been reviewed and extended.
Chief People Officer	The Chief People Officer must be informed of all serious concerns and will provide guidance about the Human Resources (HR) process within the organisation, the options available, and the manner and tone that is employed. As a member of ROAG, they are part of the strategic discussion on how to manage a practitioner about whom a concern has been raised. In addition, they are responsible for: • ensuring all case managers and case investigators are appropriately trained. • ensuring members of ROAG, case managers and case investigators are supported by the HR team as necessary. HR expertise should be used at all parts of processes to provide expert procedural advice and ensure appropriate recording and documentation of processes. • receiving appeals against actions taken in accordance with this policy and making associated arrangements • providing expert knowledge of employment law. This is particularly important in the initial phases of a serious investigation that may lead to a dismissal. Conduct or capability issues are usually managed through MHPS, but the Chief People Officer will advise on whether other reasons for termination of a contract (redundancy, breach of statutory restriction and some other substantial reason 'SOSR') may apply. • **Panel Hearings:** The Chief People Officer has an important role in the management of panel hearings, including ensuring panels are diverse where possible. The role includes advising on issues of procedure and law and the level of appropriate

	sanctions, with a view to achieving consistency. It also includes ensuring the practitioner has appropriate support and representation, knows exactly what charges they face, and has a genuine opportunity to state their case. HR provides support to the chair of any hearing to ensure the organisation has acted reasonably, has carried out a thorough investigation, and has a reasonable belief that the conclusions drawn from the investigation are correct.
Executive People & Organisation Development Group	The Executive People & OD Group is responsible for the approval and performance management of the contents of this policy. It is also responsible for promoting adherence to the requirements of this policy.

Appendix 3: Abbreviations and Definitions

AMD	Associate Medical Director
CD	Clinical Director
DMD	Divisional Medical Director
GDC	General Dental Council
GMC	General Medical Council
GMC ELA	GMC Employer Liaison Advisor
LNC	Local Negotiating Committee
MHPS	Maintaining High Professional Standards
CMO	Chief Medical Officer
MPIT	Medical Practice Information Transfer
NHSR	NHS Resolution (formerley NCAS – National Clinical Assessment Service)
PPA	Practitioner Performance Advice
RO	Responsible Officer
ROAG	Responsible Officer Advisory Group
SOSR	Some Other Substantial Reason

Appendix 4: Disciplinary Protocol

Disciplinary protocol between the University of Liverpool and NHS Trusts based on *Maintaining High Professional Standards in the Modern NHS Guidance on Clinical Academics* 2005

1. The following general principles and procedures are the result of agreement between the University and the Trust in which University Consultant Clinical Academic Staff may hold honorary NHS contracts and is intended to provide a protocol for co-operation between the University and the Trust as employers of the Consultant Clinical Academic Staff. This also applies to NHS staff who hold honorary academic contracts with the University.

General Principles

2. Consultant Clinical Academic Staff may have a substantive academic contract and an honorary NHS contract (or vice versa, a substantive NHS contract and an honorary academic contract). The honorary contract has some employment contract characteristics and can be construed as an employment contract. Normally honorary contracts are used to authorise work to be carried out for the honorary employer. In employment law a member of the Consultant Clinical Academic Staff can therefore be regarded as having two employers. Each of them will have obligations to the employee under their respective contract and arising (for example under Statute) from the relationship generally.

3 However, the University and the Trust recognise that, as far as possible, those separate relationships should be dealt with together as they are effectively parts of the same employment. This reflects the fact that the performance of the clinical duties under the honorary NHS contract (or substantial academic duties under the honorary University contract) is usually essential for the full and proper performance of the duties under the substantive academic contract (or the substantive NHS contract).

4. The University and the Trust therefore seek to ensure joint co-operation in their dealings with members of the Consultant Clinical Academic Staff.

5. The University and the Trust (The Parties) have entered into a joint agreement for the investigation into concerns about Consultant Clinical Academic Staff, where the substance of the allegations involve or may involve both clinical and academic issues. For the purposes of this policy, the Parties have agreed to jointly investigate any such matters as set out in this protocol where the issue is relevant to performance or non-performance of both the honorary and substantive contracts. The Parties have agreed to share personal and sensitive data relevant and necessary to the handling and investigation of concerns and to work together within the time frame set out in the protocol to facilitate the effective operation of the relevant performance management procedures.

Contracts of Employment

6.The University and the Trust will seek to ensure that their contracts (honorary or substantive) contain provisions which facilitate such joint co-operation and shall discuss on a regular basis the contents of the contracts which each will issue to Consultant Clinical Academic Staff. Both the Trust and the University

understand their obligations to gain approval for changes to contracts through their internal machinery. (**Appendix 2** and **Appendix 3**)

7. The University and the Trust will ensure that their contracts of employment and procedures are as far as possible sufficient to allow the disclosure of information from one to the other (of personal data or sensitive personal data) under the Data Protection Act 1998, whether with or without consent of the member of staff concerned. The Trust and the University will also discuss and agree guidelines for the disclosure of data regarding third parties, in particular data relating to patients.

Disciplinary and other Procedures

8. The University and the Trust acknowledge that, as employers of the Consultant Clinical Academic member of staff, each may wish, during the employment of the individual concerned, to act in respect of matters such as (not exhaustive):

a) Misconduct or alleged misconduct
b) Capability
c) Performance of the duties of employment to a satisfactory standard
d) Assessing medical fitness to undertake all or part of the duties of employment (including consideration of the making of reasonable adjustments under the Equality Act 2010 where the obligation to make such adjustments applies)
e) Attendance
f) Redundancy or other re-organisation.

9. It is essential that joint working extends to the prior phase of managing and helping performance issues and seeking remedial measures. It is only when these have run their course without success that formal procedures should be implemented.

10. Whilst each employer may wish to take action separately from the other, or be in the process of managing performance issues, each undertakes to inform the other party in confidence as soon as issues arise or action is contemplated in accordance with national guidelines contained in "Maintaining High Professional Standards in the NHS –Guidance on clinical academics". June 2005

(The framework is attached at **Appendix 2** "Joint Framework for Managing Clinical Academics")

11. The University and the Trust acknowledge that each has the following procedures for determining such issues in respect of its relationship with the member of the Consultant Clinical Academic Staff:

a. Trust
- Statutory Procedures for Appointment of Consultants
- Maintaining High Professional Standards in the Modern NHS
- Policy and Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff – E27
- Consultant Recruitment Procedure

b. University

- University Recruitment and Selection Code of Practice
- University Capability Procedure
- University Disciplinary Procedure
- University Grievance Procedure
- University Sickness Absence Procedure for addressing Short and Long-Term Sickness Absence

12. The University and the Trust acknowledge that:

1. There may be occasions on which the University has grounds for considering action under its appropriate procedure(s), and the Trust does not (and vice versa);
2. There may be occasions on which the University has grounds for considering action under its appropriate procedure(s) and the Trust also has grounds for considering action against the same employee under Its own appropriate procedure(s) or vice versa; and
3. If the case arises that either the University or the Trust ultimately terminates the substantive or honorary contract (as the case may be), the other will need to consider whether, in the light of that termination, the remaining contract can be continued or ought to be terminated and that, while each case will need to be considered on its own facts, it is appropriate for the University and the Trust to agree in general terms a Framework for the joint handling of such matters.

13. The University and the Trust therefore agree that the following issues are matters which would ordinarily fall to be dealt with under the University's procedure(s):

a) Serious breach or breaches of contractual terms within the academic contract.
b) Teaching, Research, Conduct relating to the University managerial and academic processes and systems.
c) Personal conduct relating to the University contract e.g. theft / fraud / misuse of university facilities.
d) Health and safety issues related to the University.
e) Standards of work related to academic, teaching and University and related activities.
f) Behavioural issues within the University contract whether that amounts to bullying or harassment or discrimination or other behaviour in contravention of University policies and procedures.

This is a representative and not exhaustive list.

14. The following issues are matters which would ordinarily fall to be dealt with under the Trust's procedure(s):

a) Breaches of contractual terms and conditions of employment within the NHS Trust contract.
b) The clinical teaching role
c) Capability within the Trust contract
d) Conduct that contravenes the Trust Conduct policy and the required standards of professional behaviour.
e) Non fulfilment of Trust responsibilities due to irregular or prolonged absence.
f) General employment issues and bringing the Trust into disrepute

This is a representative and not exhaustive list.

In cases where an issue arises under both 13 and 14 above, the University and the Trust will together determine the facts of each case and decide which procedure will take priority. Where the issue or issues

are unclear in terms of the respective employment relationships, the University and the Trust will either jointly investigate or act jointly in the investigation in accordance with this protocol.

15. In cases of Research Misconduct, reference will be made to the "Joint Policy for Investigation into Research Misconduct between the University of Liverpool and the NHS Trust" (**Appendix 3** under review).

Joint Working Procedures when there is a Potential for Informal or Formal action

Where either the University or the Trust has concerns about a member of the Consultant Clinical Academic Staff:

16. It may be the opinion of one organisation that the matter or issue of concern does not necessitate the instigation of a performance management process or investigatory process. However, in this case, information should be shared in confidence with the other organisation as soon as is feasible and, in any event, within one month of the decision not to take action. The information shared should include sufficient detail for the other organisation to determine whether there is any impact on their contract.

17. If a party is considering initiating performance management proceedings, for example, investigation, restriction of practice, exclusion, disciplinary processes, that party shall notify the other of that fact and shall discuss with the other the circumstances which have led it to contemplate initiating proceedings. The points of contact should be the Trust CEO and the University Executive Pro-Vice Chancellor for the Faculty of Health and Life Sciences.

18. The University and the Trust will co-operate with each other to facilitate any investigation into any concerns or allegations.

19. The University and the Trust shall consider whether it is the case that both parties would have grounds for initiating informal or formal proceedings and, if that is the case, agree whether action is to be taken under each of their appropriate procedures and the sequence in which those procedures shall be operated (and if both, which procedure shall take priority).

20. The University and the Trust shall discuss whether it is appropriate to consider restriction of practice or exclusion from work of the member of staff in relation to either the academic duties or clinical duties or both, and the impact on either party. Any party considering restriction of practice or exclusion from work of the Consultant Clinical Academic shall advise the other of its intention where it is practicable to do so. There may be cases where immediate exclusion is necessary and, in these cases, discussions between the parties must take place within 24 hours of the exclusion wherever possible.

If the Trust needs to restrict duties or exclude a member of staff, the doctor's RO or representative must discuss this with PPA and, in accordance with "Maintaining High Professional Standards in the Modern NHS" (MHPS), update PPA regularly. The RO will also discuss the case with the GMC ELA and, if it is believed that there is a danger to patients or the public, the GMC /GDC will be informed.

The employer who restricts/ excludes needs to update the other party on a four-weekly basis.

21. Where it is the case that formal action including investigation, restriction of practice or exclusion are being considered (or immediate exclusion has taken place) by one or both parties, a meeting should take

place between both parties to consider the appropriateness of the exclusion and how matters will be most appropriately progressed.

22. In cases of sickness absence or medical incapacity, the University and the Trust shall discuss whether it is necessary to obtain a medical report from an Occupational Health Physician or from an independent medical expert on the ability of the member of staff to perform the duties of his/her employment. The University and the Trust will discuss the questions/ issues to be raised with the medical adviser, in particular any issues arising under the Equality Act 2010, including any duty to make reasonable adjustments.

23. The University and the Trust shall liaise with each other on the steps to be taken under the applicable procedure(s)/policy(s), in particular regarding representation by both employers on any panels established under any of their applicable procedures and the facilitation of the calling of witnesses and the production of documentary evidence necessary for the purpose of determining whether concerns are founded.

24. The University and the Trust shall keep each other informed of actions taken under their applicable procedures including the outcome of any appeal.

25. While the University and the Trust shall co-operate with each other as described above, and in accordance with the Framework For Managing Consultant Clinical Academic Staff, each acknowledges that the other has the ultimate right to determine through their own procedures, whether or not formal proceedings should be instigated, to determine outcome and, if so, whether informal action, formal action and ultimately dismissal is the appropriate sanction to be applied on the facts of that case. Representation of the Trust on the University's disciplinary panels (and vice versa) does not ordinarily mean that the Trust's representative is deciding on behalf of the Trust, what sanction if any should be applied on behalf of the Trust (and vice versa).

Communication

26, In all cases communication would take place between the Trust CEO and Chief People Officer and the University Executive Pro-Vice Chancellor for the Faculty of Health and Life Sciences and Director of Workforce Development who may agree the dedicated contact points within their respective organisations.

Investigation

27. **The investigation falls firmly within the honorary NHS contract**; the Trust investigates in accordance with national guidelines and local policy. The investigation should be completed within four weeks, and the report produced within five days. In accordance with MHPS this period may be extended in complex cases.

28. **The investigation falls firmly within the substantive University contract;** the University investigates in accordance with University procedures. The University in accordance with its duty of care to employees will inform the member of staff and the Trust of the appropriate timescales.

29. If it is unclear where the investigation may lead to, in particular where clinical and research issues blur the contractual boundaries, the Trust and University will act as one body subject to complying with the timescales and process delegated to the Trust in MHPS and in conjunction with the "Joint Policy for

Investigation into Research Misconduct between the University of Liverpool and the NHS Trust" (under review).

Instigation of Disciplinary Procedures

30. Where instigation of disciplinary procedures has been decided and the action to take forward rests with one employer they will proceed in accordance with their internal policies and procedures. Where both parties have grounds for instigating disciplinary procedures, the sequence of that action must be decided.

Other general provisions regarding co-operation

31. The University and the Trust will ensure that rights of appeal will be confined solely to the procedure being implemented and individual employees may not appeal across procedures to the other party, nor may they use the other party's grievance procedure to bring a grievance in relation to the application of a procedure by the first party.

32. The University and the Trust shall meet on a regular basis to review this Agreement and its operation.

33. This document is to be read and implemented in conjunction with the following documents:

a) Joint Framework for Managing Consultant Clinical Academic Staff, **Appendix 2**
b) Joint Policy for Investigation into Research Misconduct between the University of Liverpool and the NHS Trust, Appendix **3**
c) National Framework Maintaining High Professional Standards in the Modern NHS

Appendix 5: Joint Framework for Managing Clinical Academics

This document identifies the rules of engagement, timescales, processes and key personnel involved in managing employment issues in relation to clinical academics who have substantive and honorary contracts with the University and NHS Trust.

The framework addresses the handling of issues relating to the following employment policies and procedures (as identified in paragraph 7 of the Disciplinary Protocol Between Liverpool University and NHS Teaching Trusts based on the DOH document" Maintaining High Professional Standards in a Modern NHS). The procedures are to include the following:

- Recruitment
- Appraisal
- Disciplinary
- Capability
- Sickness and Absence
- Redundancy

Background and Principles

As far as is possible this framework builds on the Department of Health document "Maintaining High Professional Standards in the Modern NHS" and the guidance on clinical academics. This document states that "joint working must be the norm "and "must extend to the prior phase of managing and helping performance and seeking remedial measures."

In keeping with those key principles, the following rules of engagement are agreed:

1. Recruitment will be handled jointly in line with good employment practice and ensuring that the recruitment to clinical academic posts maximises the opportunities for both organisations. The outcomes of this process should feed into the appraisal process and development of job planning and research and teaching profile for each post. NHS employers will fully participate in the recruitment to joint medical appointments and will nominate appropriate representation on University Search Committees to ensure that both organisations can maximise the opportunities presented by the appointment and ensure clarity of purpose of the post.

2. Annual appraisal processes and information will be joint and shared by both parties reflecting the detail identified in paragraph 12 of the Outline protocol between the University and the Trust. If other concerns regarding employment procedures become apparent during the year these will be shared in confidence in accordance with the recommended timescales in the section on Joint Processes and Joint Working regardless of whether they present as issues falling within the parameters of only one contract. The permission of the employee will be sought to exchange personal and confidential information between both employers. The interdependency clause protecting both parties.

3. Whilst recognising that a Disciplinary issue may occur within part of the contract, for example, academic teaching or direct clinical care, in working jointly both parties agree to share

relevant information so that the other party may anticipate any consequences on/within their part of the contract.

4. In relation to any investigation regarding research both organisations will jointly investigate within the timescales prescribed in "Joint Processes and Joint Working". And in accordance with the "Joint Policy for Investigation into Research Misconduct between Liverpool University and the NHS Trust ".

5. Sickness and Absence management- where this relates to long term absence and capability issues, the parties should seek to use one policy and one Occupational department by agreement in consideration of how the problem was manifested. Where the issue relates to short term infrequent absence and has been manifested within the clinical contract, given the difference in the impact of this on the respective organisations, this should be dealt with in the clinical contract.

6. Where a service or other change could potentially impact on the continuation of a post, for example, a redundancy situation, this potential should as far as possible be addressed within the management of the annual review process, failing this, at the earliest possible stage and certainly no later than the requisite notice period.

Joint Processes and Joint Working

1. Matters and issues related to employment that does not necessitate the instigation of a performance management process or investigatory process should be shared in confidence as soon as is feasible and in any event within one month of the decision.

2. Where a performance management issue is identified it will be the line manager's responsibility to inform the other organisation before the management process is started - the detail shared to include sufficient detail for the other organisation to determine whether there is any impact on their contract.

3. Where either organisation is considering any of the following it is incumbent on them to follow the agreed supporting protocol(s):

   a) Restriction of duties/suspension/exclusion
   b) Investigation general matters
   c) Investigation for potential gross misconduct
   d) Investigation relating to research misconduct
   e) Disciplinary proceedings relating general matters not clinical issues e.g. conduct
   f) Disciplinary proceedings relating to potential gross misconduct e.g. theft/fraud
   g) Disciplinary proceedings related to clinical matters

Communication

In all cases this would take place between the NHS Trust CEO/CMO and the University Dean of Medicine and Director of Human Resources who may agree the dedicated contact points within their respective organisations and vice versa.

Timing

With the exception of (b) and (e) it would be expected that the potential to act would be communicated within 24 hours and wherever possible potential issues shared proactively.

Action

With regard to a, c, d and f, and dependent on whether the decision to restrict duties has been taken, both parties will need to meet within 3 working days. If the CEO and Vice Chancellor or their designated officers are not available, it is incumbent on both parties to nominate a designate to act on their behalf.

Restriction of Duties and Exclusion

If the Trust needs to restrict duties, the Trust's RO or representative must discuss the case with PPA, and in accordance with national policy "Maintaining High Professional Standards in the Modern NHS" (MHPS) update PPA every two weeks. The Trust's RO will also discuss the case with the GMC ELA and, if it is believed that there is a danger to patients or the public, the GMC /GDC will be informed. The University and or Trust dependent on the case will need to decide whether one or both restrict or exclude and the impact of that on either party. The employer who restricts or excludes needs to update the other party on a four-weekly basis.

Investigation

If the investigation firmly falls within the NHS honorary contract that employer investigates in accordance with national guidelines and local policy. The investigation will normally be completed within 4 weeks, and the report produced within 5 days. This period may be extended in accordance with MHPS. The University in accordance with its duty of care to employees will inform them of the appropriate timescales.

If it is unclear where the investigation may lead, where clinical and research issues blur the contractual boundaries, the Trust and University will act as one body subject to complying with the timescales and process delegated to the NHS in "Maintaining High Professional Standards in the Modern NHS" and as described in the "Joint Policy for Investigation into Research Misconduct between Liverpool University and the NHS Trust".

Disciplinary Procedures

Where the instigation of disciplinary procedures has been decided, and the action to take forward rests with one employer, they will proceed in accordance with internal policies and procedures. Where in accordance with paragraph 10 of the draft protocol, both parties have grounds for instigating disciplinary action, the sequence of that action must be decided.

Disciplinary Rules

In order to ensure consistency of practice across both contracts and expectations on standards of behaviours the Trust and University will act in accordance paragraph 9 of the Disciplinary Protocol Between Liverpool University and NHS Teaching Trusts based on the DOH "*Maintaining High*

Professional Standards In a Modern NHS ".

Appendix 6: Joint Policy for Investigation into Research Misconduct between the University of Liverpool and Liverpool University Hospitals FT

1. Policy Statement

1.1 The following general principles and procedure are the result of an Agreement between the University and such NHS Trust and Provider Units (hereafter called "The Trust") in which University clinical academic staff may hold honorary NHS contracts and is intended to introduce a framework for the joint handling and investigation of research misconduct.

1.2 Clinical academics are subject to this procedure in relation to their honorary NHS contract and substantive academic contract and under the arrangements between the Trust and the University in the Protocol agreed between them.

2. Definition

2.1 Research misconduct is defined as any activity, behaviour, or practice, which causes harm, damage or loss to any property, property right, or individual including patient/s, students, employee/s, contractor/s, sub-contractor/s, visitor/s or other third party/ies as a result of any medical, pharmaceutical or other unauthorised research or any such related unauthorised activity. Any research or activity related to research, which while authorised by the parties to this Agreement, is carried out in a negligent, wilful, or substandard manner is covered by this definition which is non-exhaustive.

2.2 Clause 2.1 above, applies where a clinical academic improperly appropriates property, property rights, contributions, ideas, materials or data belonging to either party to this Agreement or to any third party (including but not limited to all categories of persons set out in clause 2.1 above), or to any activity, behaviour or omission that impedes or interferes with the progress of authorised research, or that risks corrupting the clinical research record or compromising the reputation and standing of either party to this Agreement.

2.3 Clause 2.1 covers all clinical research practices that are unauthorised, unethical, and unacceptable (or authorised but carried out negligently or improperly) and applies to the proposing, conducting, reviewing and monitoring of clinical research and to reporting the progress, benefits and results of clinical research to either party or to any third party involved in any research activity.

3. Scope

3.1 Where a research misconduct issue as defined herein arises or becomes apparent in relation to a clinical academic, the nature of the issue should be notified to the other party to this Agreement (The Trust or the University respectively) within 3 working days

3.2 The Personnel/ Human Resource Directors of the Trust and the University concerned will consult to discuss the required stages of investigation of the issue and the application of the relevant procedure and will take advice as appropriate, for example, from the Registrar.

3.3 At this stage it will be necessary to determine whether the nature of the issue rests on the academic or clinical component of the contract of employment.

3.4 If an issue/s for investigation fall solely within the University Clinical Contract, it will be a matter for the University to determine whether it is appropriate for the institution of good cause procedures or any other relevant part of the University's disciplinary procedure.

3.5 If the issue/s for investigation falls solely within the NHS honorary contract, then the Trust will investigate in accordance with the national guidelines and local policy.

3.6 The party which investigates under clause 3.4 or 3.5 will notify the other at each stage of the proceedings including both the outcome and any appeal decision. Copies of any relevant documentation and correspondence will be sent to the non-investigating party for placing on the clinical academic's personnel file.
If it is unclear where the investigation may lead, where the clinical and research issues blur the contractual boundaries, the Trust and Liverpool University will act as one body and will investigate and co-operate in accordance with this policy. This clause would apply if an investigation commenced under 3.4 or 3.5 above subsequently uncovers issues of both clinical and academic concern.

4. Procedure

4.1 All serious concerns should be registered with both the Vice Chancellor of the University and the Chief Executive of the Trust. Together the Vice Chancellor and the CEO will designate a case manager from each of the respective organisations to oversee the case and ensure momentum is maintained. This will be the Case Management Team (CMT). The CMT will be responsible for ensuring that the momentum is maintained. All concerns will be investigated quickly and appropriately. The CMT will work together to decide the appropriate course of action.

4.2 At each stage of the handling of the case consideration will be given to the involvement of PPA.

4.3 The first task of the CMT will be to identify the nature of the problem or concern and 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 decision should be taken following consultation with PPA, the Director of Workforce Development from both parties and also the CMO and an appropriate person from the University.

4.4 Where it is decided that a formal route needs to be followed (perhaps leading to conduct or capability procedures) the Vice Chancellor and the CEO will appoint a Case Investigator from each of the respective organisations. The Case Investigation Team (CIT) will investigate any allegations or concerns regarding the research misconduct of a clinical academic. The CIT will:

4.4.1 Consider whether an external, independent person should be appointed to lead the investigation, establish the facts, and report the findings

4.4.2 Formally involve a senior member of the medical staff where a question of clinical judgement is raised during the investigation procedures and formally involve a senior member of the academic staff where a question relating to the substantive contract is concerned.

4.4.3 Ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Where there are issues of Patient confidentiality ensure it is maintained. As the disciplinary panel will need to know the details of the allegations, it is the responsibility of the CIT to judge what information needs to be gathered and how – within the boundaries of the law – that information is to be gathered.

4.4.4 Ensure that sufficient written statements are collected to establish a case prior to a decision to convene a disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report.

4.4.5 Ensure that a written record is kept of the investigation, the conclusions reached, and the course of action agreed by the CIT.

4.5 The CIT members shall not make the decision on what action shall be taken nor whether the clinical academic shall be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.

4.6 The CIT has a wide 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 to limit the investigation to relevant issues.

4.7 If during the investigation it transpires the case involves more complex clinical issues than first anticipated then the CMT will consider whether an independent practitioner should be appointed from another NHS body to assist with those issues.

4.8 The CIT investigation will normally be completed within 4 weeks, and the report produced within 5 days.

4.9 The report must give the CMT sufficient information to make a decision on whether:

4.9.1 there is a case of research misconduct that should be put to a Research Misconduct Panel.

4.9.2 whether restrictions on practice or exclusion from work should be considered.

4.9.3 where a case of research misconduct is to be put before a Research Misconduct Panel, the Panel will be chaired by an independent, external suitably qualified or experienced person and will have two other members – one from the Trust and one from the University. No member of the panel will have been previously involved in the investigation or any other relevant matter.

4.10 While the University and the Trust shall co-operate with each other as described above, each acknowledges that the other has the ultimate right to determine whether

disciplinary proceedings should be instigated, to determine whether misconduct has occurred and, if so, whether dismissal is the appropriate sanction to be applied on the facts of the case. Representation of the Trust on the University's disciplinary Panel (and vice versa) does not mean that the Trust's representative is deciding whether the Trust's contract with the clinical academic concerned is to be terminated (and vice versa).

4.11 The Clinical academic will have the right of appeal. The Appeal Panel will consist of three members. An independent, external person and two other members – one from the University and one from the Trust. The members of the Appeal Panel must not have had any previous involvement in the matters that are the subject of the appeal.

4.12 Rights of appeal will be confined solely to the procedure which is being implemented and the clinical academic may not appeal across procedures to the other party (the University or Trust as appropriate).

Contractual clause to add to the honorary and substantive contracts

In addition to University/Trust disciplinary procedures, as a person employed under both a substantive contract with the University and an honorary contract with the Trust and understanding that the University and the Trust (the Parties) have entered into a joint agreement for investigation into alleged research misconduct by clinical academics, where the issues being investigated are relevant to both the substantive and honorary contracts, in recognition of the said Agreement, I agree to abide by its provisions and comply promptly with all applicable procedures. I understand that the Parties may need to share personal and sensitive information to give effect to the joint Agreement and consent to waive any confidentiality as regards information passing between the parties whether that relates to clinical, academic or any other relevant matter.

I have read and understood the joint agreement and in particular, the definition of clinical research misconduct contained therein.

Appendix 7: Preliminary Fact-Finding Checklist from LUHFT's Disciplinary Policy

This checklist must be completed by the Line Manager **BEFORE** making a referral to the authorising Senior Manager to make a decision to commence a formal disciplinary investigation:

Care Group/Specialty/Department:	**Your Name:**
Date alleged incident took place:	**Date you were made aware:**
Brief description of alleged incident:	
Outcome of discussion with HR:	
Senior Managers Comments:	
Senior Manager Approval:	**Name:**

	Signature: **Date:**

	Indicator	**Tick applicable answer**	**Considerations and further information**
INFORMAL ACTION	Have you previously had informal discussions with the member of staff about this issue or similar issues in the same way you would with any other employee?	**Yes** **Not Sure** **No**	The Trust's Disciplinary Policy emphasises conversations of concern and an opportunity for informal action to bring about improvement and learning; as opposed to punishment
HARM AND/OR DAMAGE CAUSED	Did the individual actions result in harm or damage?	**Yes** **Not Sure** **No**	If **Yes** or **Not Sure** commence a preliminary investigation to establish facts
	Did the individual knowingly breach known rules, safe operating procedure and/or breach Trust values and behaviours?	**Yes** **Not Sure** **No**	If **Yes** evidence the professional body and/or Trust rules, Trust Values and Behaviours that were breached
	Is there evidence the employee took an unacceptable risk?	**Yes** **No**	If **Yes** provide a brief summary of the evidence:

CAPACITY	Did mental or physical ill health contribute to the alleged incident?	**Yes** **Not Sure** **No**	If **Yes** underlying health conditions should be taken into consideration when deciding the next step. OH can provide guidance on the likelihood of any medical condition contributing to or impacting an incident If you're **Not Sure** then a discussion should take place with the individual and then a referral to OH for further advice

	Indicator	**Tick applicable answer**	**Considerations and further information**
CAPACITY (continued)	Have you considered other mitigating circumstances e.g. home/family etc?	**Yes** **No**	Discuss with the employee if there are any circumstances with may have impacted upon performance or decision making
	Was the employee under the influence of a substance and/or is there a history of known substance abuse?	**Yes** **No**	If **Yes** seek further guidance from HR and OH. Consult the policy on substance misuse.

SKILLS AND KNOWLEDGE	Is there a protocol / procedure / policy that refers to the expected standard of behaviour / conduct?	**Yes** **No**	If **Yes** please detail protocol / procedure / policy.` Is the protocol / procedure / policy clear? If **No**, should there be one to provide staff with the applicable framework for expected standards of behaviour and care?
	Have you reviewed the member of staff's skills and competency and determined if they knew of the rules or performance standard? Does the individual have the knowledge and skills?	**Yes** **No**	If it's evident the individual did not have the knowledge / skills or awareness
	Does the member of staff have the knowledge and skills, but did not apply this?	**Yes** **No**	If the member of staff knows how to and can in practice, but isn't then continue with formal investigation
	Would you expect a different member of staff in a similar role / position with similar experience to act in a similar manner?	**Yes** **No**	

	Indicator	**Tick applicable answer**	**Considerations and further information**
Comparator	As the manager how well have you read and reacted to the situation?	**Proportionately** **Disproportionately**	Consider whether unconscious bias contributed to your decision. **Unconscious bias** can often show up as micro-behaviours (the little things that we say and do that show how we regard those around us)
	Have you created the right relationship with the employee?	**Yes** **No**	
	Is the action you're considering consistent with how other employees within your team have been treated for the same or similar misconduct or action?	**Yes** **No**	If No why have you chosen to consider disciplinary action on this occasion? Provide explanation: By carrying out an investigation for disciplinary action against this employee you need to ensure this action is consistent with how other employees have been treated for the same or similar misconduct / action.

Appendix 8: Learning Lessons to improve people's practice – NHSE, 2019

2019.

Chief Executive and Chair's Office
Wellington House 133-155 Waterloo Road London SE1 8UG
Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective application of local policies and procedures; lack of adherence to best practice

guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate, and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's recommendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures.

Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be

allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

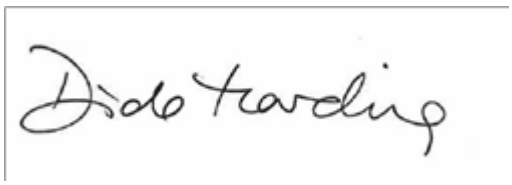
- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and i informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes



Baroness Dido Harding

Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures
Copies:
Chair, Care Quality Commission
Chair, NHS Providers

Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

NHS England and NHS Improvement

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any

suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Appendix 9: Exclusion framework for doctors and dentists

Exclusion framework for doctors and dentists
The questions to ask yourselves (Source: NHSR)

Immediate Exclusion

- Why are you considering "immediate exclusion"?
- Has there been a critical incident and serious allegations?
- Has there been a breakdown in relationships between a colleague and rest of team?
- Is the presence of the practitioner likely to hinder investigation?
- Is there a workable alternative to immediate exclusion?
- Do you think the practitioner will honour the alternative to immediate exclusion?
- Are you able to explain reasons for immediate exclusion to the practitioner?
- Will you advise the practitioner of their rights?
- Have you agreed a date for a further meeting with the practitioner?
- Have you made plans to carry out a preliminary situation analysis?
- Have you made plans to convene a case conference within the 2-week period?
- Who is to be the Case Manager?
- Are you going to deal with the issue formally or informally?
- What other managers will be involved in progressing the case?
- Have you appointed a Case Investigator?
- How will the clinician's absence be reported to the immediate clinical team?

Formal Exclusion

- Why are you considering formal exclusion?
- Have you seriously considered other possible ways of dealing with the issue?
- Have you considered voluntary exclusion?
- Have you considered further training?
- Have you considered joint referral to PPA?
- Is sick leave appropriate?
- Have you considered redeployment to non-clinical work or to other sites/ NHS bodies?
- Have you considered a restriction to practice?
- Do you feel reasonable assured that any alternative would be honoured?
- Have you ascertained details of the incident that leads you to think that formal exclusion is appropriate?
- From what part of their role are you proposing to exclude the practitioner?
- What is your case management plan that will achieve resolution?
- Have you thought beyond the immediate period?
- Is your plan realistic, based on good practice, using correct procedures?
- What is your approximate timetable?
- What urgency and priority can you give to this?
- Is your timetable realistic?
- Has the practitioner expressed a view about the proposed exclusion?

- Would the practitioner willingly co-operate with a full or partial exclusion?
- If the practitioner disagrees what is your plan to deal with this?
- Have you drawn up a plan for responding to media inquiries?
- What are you going to tell the other staff that need to know or will ask?

Appendix 10: Return to Practice Planning – Recommended Questions and Actions

Pre-absence planning (where possible)

- How long is the Practitioner expected to be absent? Is there any likelihood of an extension to this?
- Are any training programs or installation of new equipment due to take place in the practitioner's workplace in the period of absence? If so, how should the practitioner become familiar with this on their return?
- How long has the practitioner been in their current role? Is this relevant in determining their needs?
- Will the practitioner be able to participate in any 'Keep in Touch' days or other means of keeping in touch with the workplace? If so, how will this be organised?
- Does the practitioner have any additional educational goals, during their absence?
- What sort of CPD, training or support will be needed on the practitioner's return to practice? Are there any funding issues which need to be considered?
- Will the practitioner be able to retain their licence to practice and fulfil the requirements for revalidation?
- Are there any issues relating to the doctor's next appraisal which need to be considered? If so, the RO or representative may need to be informed?
- If the practitioner is a trainee, how do they plan to return to learning?

Post-absence planning

- How long has the practitioner been away?
- Has the absence extended beyond that which was originally expected? If so, what impact has this had?
- How long has the practitioner been practicing in the role they are returning to?
- What responsibilities does the practitioner have in the post to which they are returning? Are there any new responsibilities?
- How does the practitioner feel about their confidence and skills levels?
- What support would the practitioner find most useful in returning to practice?
- Has the practitioner had any relevant contact with work and/or practice, during the absence?
- Have there been any changes since the practitioner was last in post, for example, new equipment, medication, changes to infection control, health & safety, quality assurance, NICE guidance, changes in common conditions, patient population information, developments or new practices in the specialty, changes in management/role?
- Has the absence had any impact on the practitioners licence to practice and revalidation?
- Have any new issues arisen for the practitioner since he/she was last in post which may affect confidence or ability?
- Has the practitioner been able to keep up to date with their continuing professional development?
- If the practitioner a trainee, what are the plans for a return to learning?
- Is the practitioner on a phased return to work on the advice of OH?
- Are there any issues relating to the practitioners next appraisal and preparation for this, which need to be considered? Is the revalidation date affected?

- Are there other factors affecting the return to practice or does the practitioner have issues to raise?
- Is a period of observation of other doctor's practice required and/or odes the practitioner need to be observed before beginning to practice independently again?
- Will the practitioner need training, special support or mentoring on return to practice?
  - If so, are there any funding issues related to this which need to be considered?

Appendix 11: Involvement of NHSR following local investigation

Medical under-performance can be due to health problems, difficulties in the work environment, behavior, or a lack of clinical capability. These issues may occur in isolation or in a combination. NHSR processes are aimed at addressing each one of these factors, particularly where local action has not been able to take matters forward successfully. NHSR methods of working assume the commitment of all parties to contribute constructively to the referral to NHSR. NHSR assessors work to formal terms of reference agreed after input from the practitioner and the referring body.

The focus of NHSR work is likely to involve performance difficulties which are serious and/or repetitive. That means:

- Performance falling well short of what practitioners could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk.
- Alternatively or additionally, ongoing problems or (depending on severity) have occurred on at least two occasions.

A different local process may be warranted where matters at issue focus on fraud, specific patient complaints or organisational governance. The NHSR may advise on this.

The Trust will inform the NHSR at an early stage where the exclusion of a practitioner is being considered, regardless of whether or not their performance is under discussion with the NHSR, so that alternatives to exclusion are considered. From the point of view of NHSR, it is much more difficult to carry out an assessment, should this be required, when a practitioner is excluded from practice.

A practitioner undergoing assessment by the NHSR must cooperate 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 NHSR assessment is complete. (Under circular HSC 2002/011, Annex 1, paragraph 3, "A doctor undergoing assessment by the NHSR[S] 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 the NHSR may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the employer 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.

Appendix 12: Terms of Reference for the Responsible Officer Advisory Group (ROAG)

While statutory responsibilities in relation to the Responsible Officer Regulations rest with the Responsible Officer (RO), their decision-making is assisted by discussions with an advisory group of relevantly skilled and experienced colleagues. This range of perspectives provides objectivity and consistency, helps minimise risk, and may be beneficial in ensuring consideration of all relevant aspects.

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 practise. The RO has a key role in ensuring the effective implementation of the Responsible Officer Regulations in their designated body. The ROAG supports the role of the RO and provides the opportunity for calibration of decision-making.

The group will oversee the following:

- Management of concerns about practitioners and ensuring individuals involved, including those raising concerns, those about whom concerns are raised, and those who are investigating the concerns receive appropriate support.
- Ensuring the Trust has an appropriate number of formally trained case managers and case investigators.
- Employment processes
- Monitoring of action plans following investigations
- Oversight of remediation of doctors
- Identification of best practice, areas for development and themes for wider sharing
- Other aspects relevant to the RO Regulations.

Membership
The advisory group includes:

- Chief Medical Officer (CMO)
- Responsible Officer (RO)
- Deputy Medical Directors
- Associate Medical Director (AMD) for Professional Standards
- Chief People Officer
- Deputy Chief People Officer
- Medical HR Lead

Additional members may be recruited as required for specific items as required, for example, those with governance responsibility for the practitioner such as Divisional Medical Directors or CDs.

The chair will be the RO/CMO or deputy.

Quorum
A quorum will be four members from the above list (or their deputy) including the chair.

Process

- The group will meet on a monthly basis. Additional meetings may be convened where urgent decisions are required.

- Attendees will be asked to disclose any conflict of interest at the beginning of the meeting and a decision will be made whether to exclude them from discussion of the relevant case.

- Brief notes will be made of the discussions and decisions reached, and actions assigned to a nominated individual with timescales.

- Items to be communicated to the Board, and by whom, will be agreed at the end of the meeting.

- Notes will be checked by the chair and circulated where possible within a week of each meeting.

- The agenda for each meeting will be circulated one week prior to each meeting.

- If the RO or CMO is not present the key points from the meeting will be communicated to them as soon as possible after the meeting.

- Actions assigned to a person not present at the meeting will be communicated to them by the chair, or suitable delegate, as soon as possible after the meeting.

- Documentation will be stored securely in a restricted folder on the G drive. Any papers printed and used during the meetings will be disposed of by confidential shredding following the meeting.

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

Review of Terms of Reference
The Terms of Reference for the Responsible Officer's Advisory Group will be reviewed annually.

Appendix 13: Appeal Panels in Capability Cases

Appeal panels in capability cases

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1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.
2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held national list rather than through local selection. The benefits include:

   - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
   - the ability to monitor performance and assure the quality of panel lists.

3. The following provides an outline of how it is envisaged that the process will work.

Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with the NHS Appointments Commission. NHS Employers will be responsible for administration of the list.
5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the BMA, BDA, defence organisations, the NHSR and NHS Employers. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.
6. The Department of Health, in consultation with NHS Employers, the BDA and the BMA will provide a job description based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the Judicial Studies Board. The framework, which can be adapted to suit particular circumstances sets out six headline competences featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competences.
7. Panel members will be subject to appraisal against the core competences and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.
8. The level of fees payable to panel members will be set by NHS Employers and paid locally by the employing organisation responsible for establishing the panel.
9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competences and /or seminars designed to provide background on the specific context of NHS disciplinary procedures - including the expectations of employers and representatives, could be provided with support from NHS Employers, the NHSR and other stakeholders.