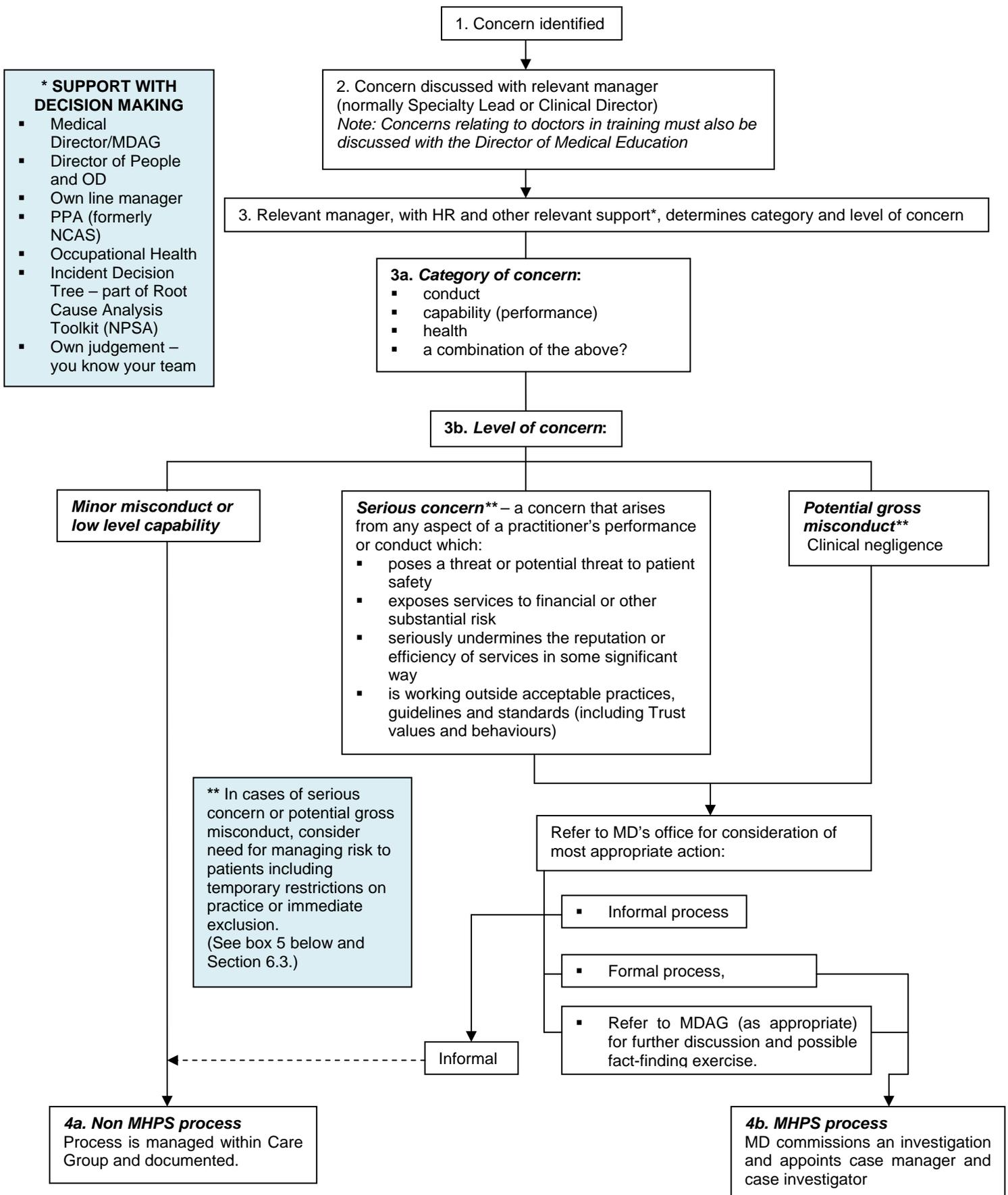


Maintaining High Professional Standards in the Modern NHS Policy

V2.0

July 2019

Summary



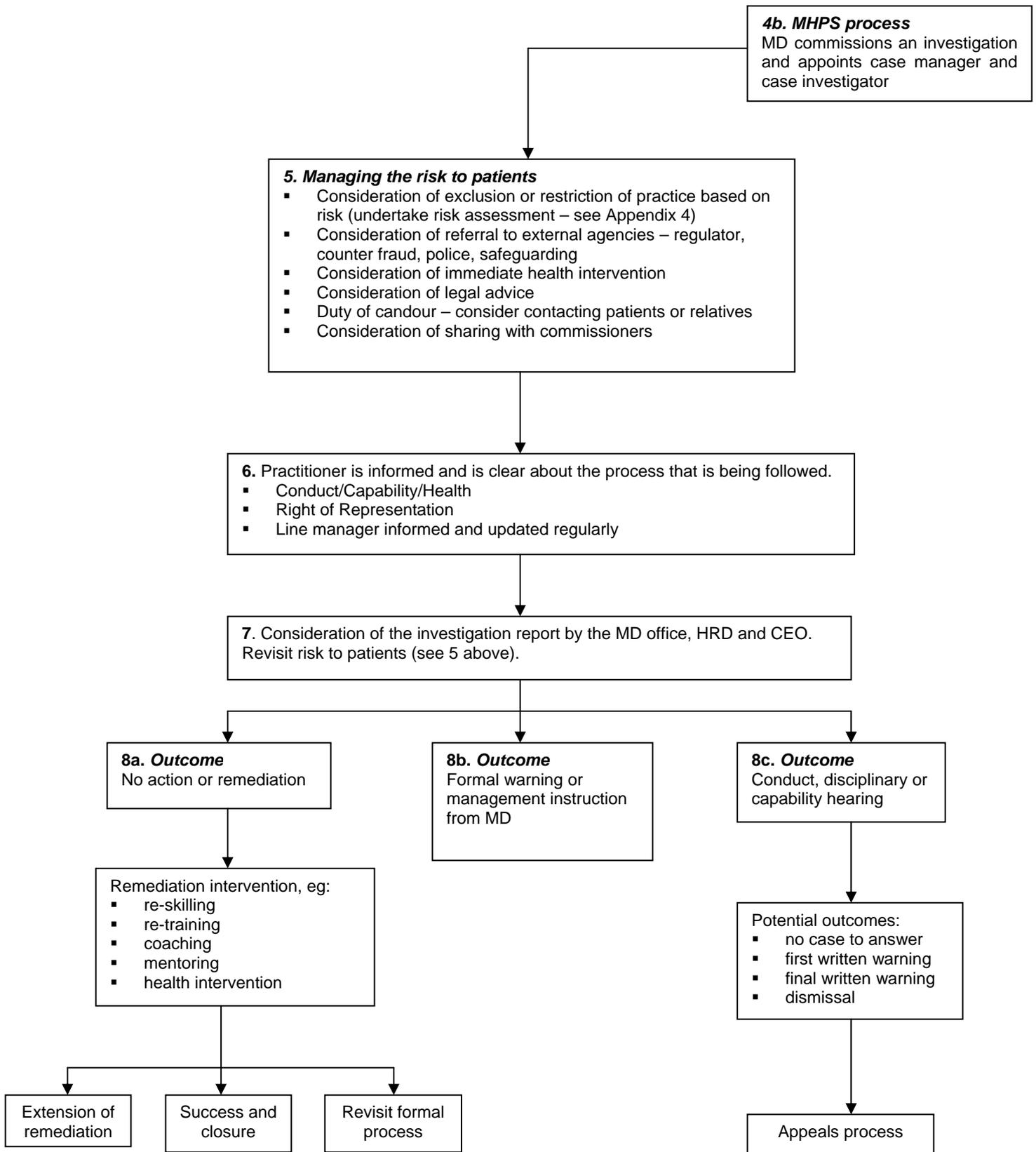


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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the *Information Use Framework Policy* or contact the Information Governance Team rch-tr.infogov@nhs.net

1. Introduction

1.1. This is an agreement between Royal Cornwall Hospitals NHS Trust (the Trust) and the Joint Local Negotiating Committee (JLNC) outlining the Trust's procedure for handling concerns about doctors' and dentists' conduct and capability. It implements the framework set out in *Maintaining High Professional Standards in the Modern NHS*, issued under the direction of the Secretary of State for Health in February 2005.

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

1.3. Where formal disciplinary action is used, it should emphasise and encourage improved standards of performance/conduct. It is not a means of punishment.

1.4. Practitioners who are subject to the formal procedures in this document will be provided with a summary of rights (Appendix 6). At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body, an official or representative of the British Medical Association [or any other recognised trade union], British Dental Association or a defence organisation, or work colleague, friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity.

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

1.6. It is a principle of these procedures that, where appropriate, issues are dealt with by the immediate clinical line manager of the practitioner.

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

1.8. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

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

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

3. Scope

3.1. This policy applies to all medical and dental staff employed by the Trust.

3.2. Medical and dental staff who hold honorary contracts with the Trust and undergraduates will also be subject to these procedures.

3.3. Where there is an allegation of misconduct or concern raised regarding performance in relation to a doctor in training, then the Director of Medical Education should be informed so that the Postgraduate Dean at Health Education England can be notified to ensure their involvement from the outset.

4. Definitions / Glossary

The following definitions and examples constitute guidance in defining the category of alleged misconduct. It is for the Medical Director to decide into which category a case falls:

- **Conduct** - where the conduct or behaviour of a doctor or dentist:
 - ❖ falls below that expected as set out in *GMC Good Medical Practice (2013)* as amended, http://www.gmc-uk.org/guidance/good_medical_practice.asp and/or
 - ❖ is not consistent with the Trust's values and behaviours (Appendix 6)

The Trust's *Disciplinary Policy and Procedure* will apply (see Section 6.4: Part 3 - Process for dealing with misconduct) if conduct is found to be impaired.

- **Capability** - where there is evidence of clinical practice outside that which is regarded as 'standard and acceptable' by a body of specialty opinion, eg NICE, and/or has implications for patient safety.

Opinion can be drawn from both internal sources, eg colleagues within the specialty, and external sources (particularly when there might be conflict of interest) such as clinicians from the same specialty working in other Trusts or Royal Colleges (see Section 6.5: Part 4 - Process for dealing with issues of capability).

- **Practitioner Performance Advice (PPA)** - Practitioner Performance Advice (formerly the National Clinical Assessment Service - NCAS) is now a service delivered by NHS Resolution under the common purpose to provide expertise

to the NHS on resolving concerns fairly, share from learning for improvement and preserve resources for patient care.

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

- **NHS Improvement (NHSI)** - now incorporates the former National Patient Safety Agency (NSPA) which **leads** and contributes to improved safe patient care by informing, supporting and influencing the health sector.
- **MDAG** - Medical Director's Advisory Group.

5. Ownership and Responsibilities

5.1. Role of the Chief Executive and Trust Board

5.1.1. All serious concerns must be registered with the Chief Executive and he/she must ensure that a case manager is appointed. The Trust's Chief Executive has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed.

5.1.2. The Trust Board is responsible for:

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

5.2. Role of the Designated Board Member (NED)

5.2.1. The Designated Board Member oversees the case which includes the right to a fair process and ensures momentum is maintained.

5.2.2. At any stage in the process, the practitioner may make representations to the Designated Board Member in regard to exclusion or investigation of a case. This is in addition to any right the practitioner may have to appeal against the exclusion under the Trust's appeal procedure [see paragraph 6.3.11.8)].

5.3. Role of the Medical Director

(Some responsibilities can be delegated to the case manager when the latter is not the Medical Director.)

The Medical Director is responsible for:

- the practical implementation of this policy
- deciding on the category and level of concern (involving MDAG as appropriate)
- deciding on the course of action required and who else to involve, eg: convening a meeting, as appropriate, of the MDAG group to discuss the issues or commissioning a fact finding process, the aim of which is to gather

enough information to help inform and rationalise whether the issue can be dealt with informally or needs to be addressed via the formal procedure

- recording the decision whether or not to investigate
- when not the case manager, appointing a case manager and/or case investigator. The Medical Director will act as the case manager in cases involving clinical directors and consultants or will delegate this role to a senior clinical manager
- agreeing/writing the terms of reference for an investigation or delegating this to the case manager
- considering practice restriction/exclusion, referral to the regulator, involvement of other external agencies, duty of candour, discussion with PPA, immediate health intervention, support of the individual, including through professional representation and OH support, and confidentiality
- considering the result of the investigation report and recommending any further action to the Chief Executive and Director of People and OD on conclusion of the investigation.

5.4. Role of the Director of People and Organisational Development

The Director of People and OD is responsible for:

- advising on process and assisting in decision making (including exclusion procedures) in conjunction with the CE and MD, and
- reviewing and maintaining this document in conjunction with the Local Negotiating Committee (LNC)
- collating the summary of number of cases for sharing with the board and JLNC and SMADEC Chairs.

5.5. Role of the Medical Director's Advisory Group (MDAG)

5.5.1. The MDAG, chaired by the MD, may be convened to discuss and advise the MD, CE and Director of People and OD about the approach to be adopted in a specific case.

5.5.2. Membership will vary dependent upon the issue and the specialty involved but will normally include:

- the Medical Director
- the Responsible Officer (if not the Medical Director)
- the Deputy Medical Director
- the Director of People and OD or nominated deputy

and may include where appropriate:

- the Director of Medical Education, in cases involving doctors in training, and
- Occupational Health
- Director of Integrated Governance or deputy.

5.6. Role of HR Practitioners

HR Practitioners are responsible for:

- advising on process and assisting in decision making
- attending/supporting formal meetings associated with any investigation.

5.7. Role of the Director of Medical Education

The Director of Medical Education is responsible for:

- notifying and liaising with the Postgraduate Dean at Health Education England in cases involving doctors/dentists in training.

5.8. Role of the Case Manager

The Case Manager is responsible for:

- clarifying what has happened and the nature of the problem or concern, identifying the nature of the initial problem or concern and assessing its seriousness
- discussing with PPA, what the way forward should be
- in consultation with the Medical Director, Director of People and OD and PPA, deciding whether the concern can be resolved without resort to formal procedures
- if a formal approach under the conduct or capability procedure is required, appointing an investigator in association with the MD (and MDAG as appropriate)
- agreeing terms of reference in conjunction with the MD and Case Investigator
- if the case can be progressed by mutual agreement, considering whether a PPA assessment would help clarify the underlying factors that led to the concerns and assist with identifying the solution
- ensuring any investigation is conducted efficiently
- acting as a co-ordinator between the practitioner, case investigator and others interviewed
- ensuring confidentiality, proper documentation of the process and access to any documentation required by the case investigator
- ensuring the practitioner and witnesses receive appropriate support
- determining next steps on receipt of the report from the case investigator
- preparing and presenting the management case to any panel hearing
- supervising any formal remediation programme.

5.9. Role of the Case Investigator

5.9.1. Case investigators are responsible for:

- leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings

- formally involving a senior member of the medical or dental staff where a question of clinical judgement is raised during the investigation process. Where no other suitable senior doctor or dentist is employed by the NHS body a senior doctor or dentist from another NHS body should be involved
- ensuring that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible.
- Patient confidentiality needs to be maintained but any disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how (within the boundaries of the law) that information should be gathered. The investigator will approach the practitioner concerned to seek views on information that should be collected
- ensuring that there are sufficient written statements collected to establish a case prior to a decision to convene any 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
- ensuring that a written record is kept of the investigation, the conclusions reached, and the course of action agreed by the Medical Director with the Director of People and OD
- assisting the Designated Board Member in reviewing the progress of the case, ensuring a clear audit trail is established for initiating and tracking progress of the investigation, its costs and resulting action.

5.9.2. The case investigator does not make the decision on what action should be taken nor whether the practitioner should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.

5.9.3. If, during the course of the investigation, the case investigator uncovers concerns outside the terms of reference, the case manager must be informed and only the case manager can then consider widening the terms of reference, convening/re-convening MDAG to revisit the initial framework of the investigation, such as exclusion/restriction etc.

5.10. Role of Clinical Line Managers (normally the Specialty Lead or Clinical Director)

Clinical line managers are responsible for:

- ensuring practitioners are aware of the standards of conduct expected of them
- providing help and support to assist their staff in achieving and maintaining these standards
- promptly dealing with issues of minor misconduct or poor performance
- ensuring the Medical Director is promptly made aware of any issues of misconduct or poor performance, requiring his attention, as appropriate
- ensuring any concern related to patient safety is acted on immediately within a clinical framework, including Duty of Candour and informing commissioners/HLRO/NHSI as appropriate

- in the case of doctors and dentists in training, advising the Director of Medical Education of any concerns regarding their conduct and/or capability.

5.11. Role of Occupational Health Service

The Occupational Health and Counselling Service is responsible for:

- assisting practitioners and their clinical managers with professional, work-related health advice in order to promote health and wellbeing at work
- where a referral is made (normally to the Occupational Health Consultant), agreeing a course of action with the practitioner and sending their recommendations to the Medical Director
- attending meetings with the Medical Director and/or case manager, Director of People and OD and the practitioner to agree a time-table of action and (where appropriate) rehabilitation
- where appropriate, providing reports to NHS Pensions regarding ill-health retirement applications.

5.12. Role of Individual Practitioners

All practitioners are responsible for:

- ensuring they achieve and maintain the standard of performance required of them, including adherence to the Trust values (and associated behaviours), on a consistent basis
<https://doclibrary-richt.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/CorporateServices/ValuesAndBehavioursFramework.pdf>
- ensuring they work within their professional guidelines
- ensuring they raise any issues, which may affect their performance, with their clinical line manager as soon as they occur so help and/or support can be given
- co-operating with any investigation into concerns about their performance or conduct and action taken under this policy, eg: attending appointments with Occupational Health, co-operating with a referral to PPA and/or restrictions on their practice/exclusion from work
- arranging representation, if desired, by an official or lay representative of their professional organisation or defence organisation, a work colleague or a friend, partner or spouse. Where any of the above are legally qualified they will not be able to act in a legal capacity
- in the case of exclusion from the Trust, they remain available for work during their normal contracted hours and inform their case manager of any other work (see section 6.3.8. - 6.3.9.)
- inform the Designated Board member (NED) or PPA if they have concerns about the MHPS process.

5.13. Role of Individual Staff

All staff are responsible for:

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

6. Standards and Practice

6.1. Initial Procedure

6.1.1. As a general principle, it is expected that the immediate clinical line manager of the practitioner will deal with issues of minor misconduct or performance (if necessary with Care Group HR support) without resort to the Medical Director (MD). In such circumstances, it may or may not be appropriate for the MD to be informed of the outcome.

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

6.1.3. At this stage the MD will either:

- decide that the matter can be resolved by the Clinical Line Manager (CLM) or support an informal resolution by the MD
- decide that the matter is so serious that it needs to proceed immediately under the full MHPS investigatory process (set out below in Section 6.2) or
- refer the issue to the relevant members of the Medical Director's Advisory Group (MDAG) and Care Group clinical managers as appropriate for consideration after which the MD will decide the best course of action in line with paragraphs i, ii and iii below.

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

This process will normally involve the CLM establishing the immediate facts surrounding the complaint/concern. This can include any documentary records such as timesheets, written statements from the member of staff who raised the concern and any other witnesses. At this stage readily available information is being sought.

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

The individual who the received complaint is against will need to be informed and advised that a complaint/concern has been received and

that a fact finding process to establish the immediate facts surrounding the case is being undertaken. However, this may not be appropriate where an issue eg involves potential fraud (see Section 1.5) or where it is immediately apparent that there is no case to answer.

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

Key principles of the fact finding process:

- ❖ CLM gathers readily available facts/ information that has given rise to the concern
- ❖ information is gathered surrounding the concern and complaint (as opposed to being directed by terms of reference)
- ❖ if appropriate, the individual concerned has been made aware informally that there is an issue
- ❖ no notice is required ie no invitations to formal meetings, right to representation does not arise
- ❖ process managed locally with HR support
- ❖ no formal process to follow.

Upon completion of the fact finding process a brief report will be made to the MD who, following consultation as appropriate with the Director of People and OD and/or MDAG will make recommendations for further action. These recommendations may include:

- i that there is no case to answer and no further action required, or
- ii the details of the MD's proposals for resolving the matter as an alternative to following the appropriate formal procedure. This may include remedial supportive action, further training or modification of responsibilities, job plan review, referral to the Occupational Health department or issuing a formal verbal or written warning by the MD or CE. The appropriate formal procedure will be followed if the practitioner does not agree to the MD's proposals in this regard
- iii the matter needs further investigation under the full MHPS investigating process set out below at Section 6.2.

6.2. Part 1: Action when a serious concern arises

6.2.1. Introduction

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

- ii. Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:
 - concerns expressed by other NHS professionals, health care managers, students and non-clinical staff
 - review of performance against job plans, annual appraisal, revalidation
 - monitoring of data on performance and quality of care
 - clinical governance, clinical audit and other quality improvement activities
 - complaints about care by patients or relatives of patients
 - information from the regulatory bodies
 - litigation following allegations of negligence
 - information from the police or coroner
 - court judgements.
- iii. **Unfounded and malicious allegations** can cause lasting damage to a doctor's reputation and career prospects. Therefore all allegations, including those made by relatives of patients or concerns raised by colleagues, must be properly investigated to verify the facts so that the allegations can be shown to be true or false. It therefore follows that careful judgement is required to apply the following processes.
- iv. Concerns about the capability of **doctors and dentists in training** should be considered initially as training issues and the Director of Medical Education should be informed so that the Postgraduate Dean at Health Education England can be contacted and involved from the outset.
- v. All serious concerns must be registered with the Chief Executive and he/she must ensure that a case manager is appointed. The Chairman of the Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director will need to work with the Director of People and OD to decide the appropriate course of action in each case. The Medical Director will act as the case manager or may delegate this role to a senior clinician or senior manager in conduct cases, to oversee the case on his or her behalf. The Medical Director, in conjunction with the case manager as appropriate, is responsible for ensuring the appointment of a case investigator.
- vi. **Safeguarding** - where a case involves allegations of abuse by NHS staff that indicate that young children, young people or adults at risk are believed to have suffered, or are likely to suffer, significant harm the *Managing Safeguarding Allegations Against Staff Policy and Procedure*

(NHS England 2015 page 13, 7.7.1) should be referred to for more detailed guidance. Guidance is also provided by *South West Child Protection Procedures (SWCPP)* and county wide policies on *Guidance for Responding to Allegations or Concerns about Child Abuse Perpetuated by Health Professionals and Ancillary Staff working in NHS Trusts* which provides guidance for referral to the Local Authority Designated Officer (LADO) and *Allegations against people in positions of trust* (PiPOT).

A *Framework for Managing Safeguarding Allegations* is provided in Appendix 3.

- vii. **Counter Fraud** - in any cases where fraud (as defined by the Fraud Act 2006 or Theft Act 1968) is suspected, the matter should be reported to the Trust's Local Counter Fraud Specialist immediately. Further information can be obtained from the Trust's Counter Fraud and Corruption against the NHS Policy, a copy of which is available from the Trust's document library via the following link:

<https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Finance/FinancialServices/CounteringFraudAndCorruptionAgainstTheNationalHealthServicePolicy.pdf>

6.2.2. Exclusion

- i. The duty to protect patients is paramount. When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Section 6.3.11 of this document sets out the procedures for this action.

The Risk Assessment Exclusion tool at Appendix 4 must be used prior to any action being taken about whether to immediately exclude/redeploy/ restrict/amend the duties of any staff members.

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

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

6.2.3. Identifying if there is a problem

- i. The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with the Director of People & OD, the

Medical Director (if not appointed case manager), PPA and MDAG as appropriate.

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

- ii. The case manager should explore the potential problem with PPA to consider different ways of tackling it themselves, possibly recognising the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than PPA.
- iii. The case manager should not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of adverse events should be conducted as these frequently show that causes are more broadly based and can be attributed to systems or organisational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions. NHSI facilitates the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses and the case manager should consider contacting NHSI for advice about systems or organisational failures.
- iv. Having discussed the case with PPA and/or NHSI, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen PPA should still be involved until the problem is resolved. This can include PPA undertaking a formal clinical performance assessment when the doctor, the NHS body and PPA agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps. If PPA is asked to undertake an assessment of the doctor's practice, the outcome of a local investigation may be made available to inform its work.
- v. Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Director of People & OD, appoint an appropriately experienced or trained person as case investigator and case manager (if not the MD). The seniority of the case investigator will differ depending on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained to enable them to carry out this role when required.

6.2.4. The investigation

- i. The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided that an investigation is to be undertaken, the name of the case investigator and made aware of the specific allegations or concerns that have been raised. The practitioner should be sent the terms of reference for the investigation. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the case investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied. If the practitioner fails to engage in the process the investigation will be finalised without their input.
- ii. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing. In addition to statutory rights under the *Employment Act 1999*, the companion may be another employee of the NHS body, an official or representative of the *British Medical Association*, *British Dental Association* [or any other recognised trade union] or a defence organisation, or work colleague, friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity (see paragraph 1.4).
- iii. The case investigator has discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner and report the findings. Investigations are not intended simply to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter.
- iv. If, during the course of the investigation, it transpires that the case involves more complex clinical issues than first anticipated, the case manager should arrange for a practitioner in the same specialty and same grade from another NHS body to assist.
- v. The case investigator should aim to complete the investigation within four weeks of appointment and submit their report to the case manager within a further five working days. All best endeavours will be used to complete the investigation within four weeks but, if this is not possible, an interim report will be made after the four weeks. The report of the investigation should give the case manager sufficient information to make a decision as to whether:
 - no further action is needed
 - to exercise the Medical Director's discretion to make proposals for resolving the matter as an alternative to the actions below (as set out in paragraph 6.1)
 - there is a case of misconduct that should be put to a conduct panel via the implementation of the relevant HR policies and procedures eg Trust Disciplinary or Dignity at Work policies. The MD, in

consultation with the Director of People & OD or nominated deputy, will establish which of these Trust procedures will be appropriate in accordance with the principles of the MHPS policy

- there are concerns about the practitioner's health that should be considered by the Occupational Health department and, if necessary, dealt with via implementation of the Trust's Attendance Management or Substance Misuse policies
- there are concerns about the practitioner's performance that should be further explored by PPA
- restrictions on practice or exclusion from work should be considered (see Section 6.3 and Appendix 4)
- there are serious concerns that should be discussed with the GMC or GDC
- there are intractable problems and the matter should be put before a capability panel (Section 6.5).

6.2.5. Involvement of PPA following local investigation

- i. Medical under-performance can be due to health problems, difficulties in the work environment, behaviour or a lack of clinical capability. These may occur in isolation or in a combination. PPAs' processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. PPAs' methods of working therefore assume commitment by all parties to take part constructively in a referral to PPA. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.
- ii. The focus of PPAs' work is therefore likely to involve performance difficulties which are serious and/or repetitive. This means:
 - performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk
 - alternatively, or additionally, problems that are on-going or (depending on severity) have been encountered on at least two occasions.
- iii. In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process. PPA may advise on this.
- iv. Where the Trust is considering excluding a doctor or dentist (whether or not his or her performance is under discussion with PPA), the Trust will inform PPA of this at an early stage so that alternatives to exclusion are considered. Procedures for exclusion are covered in Section 6.3 of the procedure. It is particularly desirable to find an alternative when PPA is likely to be involved because it is much more difficult to assess a practitioner who is excluded from practice than one who is working.

- v. A practitioner undergoing assessment by PPA must co-operate with any request to give an undertaking not to practice in the NHS or private sector, other than their main place of NHS employment, until the PPA assessment is complete. (Under circular HSC 2002/011, Annex 1, paragraph 3, "A doctor undergoing assessment by PPA must give a binding undertaking not to practice in the NHS or private sector other than in their main place of NHS employment until the assessment process is complete").
- vi. Failure to co-operate with a referral to PPA may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the Trust on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the parties and may necessitate disciplinary action and consideration of referral to the GMC or GDC.

6.2.6. Confidentiality

- i. In discharging its duty of care to its staff the Trust will maintain confidentiality. The information provided externally (eg to the media) will be restricted only to confirming that an investigation or disciplinary hearing is underway. The Trust will not release the name of the practitioner or issue a press notice at this stage.
- ii. Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose and not disproportionate to the seriousness of the matter under investigation. The Trust will operate consistently with the guiding principles of the *Data Protection Act 2018* (enacting the *General Data Protection Regulations*).

6.2.7. Staff support

The Trust recognises that, irrespective of the outcome, practitioners involved in this process are likely to find the experience traumatic and stressful. Support is available, at any stage of the procedure, from the Occupational Health department and the practitioner's trade union or professional body. (See also the Trust's policy on *Supporting staff involved in an incident, complaint or claim* available from the Trust's document library). It is recognised that a phased return to work may be needed following an investigation.

6.2.8. Overlapping employment relations issues and processes (disciplinary, capability and/or grievance issues)

- i. Where a staff member raises a grievance during a capability/disciplinary process, the process may be temporarily suspended in order to deal with the grievance.
- ii. However, each case will be considered on its own merits and any potential delay must be risk assessed for its impact on patient and/or staff safety using an *Impact Assessment* form (see Appendix 5). It may be appropriate to deal with both issues concurrently.

6.3. Part 2: Restriction of practice and exclusion from work

6.3.1. Introduction

- i. Please note: the phrase *exclusion from work* has been used instead of the word *suspension* which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.
- ii. The Risk Assessment Exclusion tool at Appendix 4 must be used prior to any action being taken about whether to exclude/redeploy/restrict/amend the duties of any staff members.
- iii. The Trust will ensure that:
 - exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered
 - where a practitioner is excluded, it is for the minimum necessary period of time. This can be up to, but no more than, four weeks at a time (see paragraph 6.3.3. and 6.3.5. for details re immediate exclusion)
 - all extensions of exclusion are reviewed and a brief report provided to the Chief Executive and Board
 - a detailed report is provided, when requested, to the "Designated Board Member" who will be responsible for monitoring the situation until the exclusion has been lifted.

6.3.2. Managing the risk to patients

- i. Where serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of a practitioner from the workplace. Exclusion will be considered as a last resort if alternative courses of action are not feasible. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean should be involved as soon as possible.
- ii. Exclusion of clinical staff from the workplace is a temporary expedient. It is a precautionary measure and not a disciplinary sanction. Exclusion from work will be reserved for only the most exceptional circumstances.
- iii. The purpose of exclusion is:
 - to protect the interests of patients or other staff and/or
 - to assist the investigative process when there is a clear risk that the practitioner's presence would impede or otherwise compromise or contaminate the gathering of evidence
- iv. It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must

depend on the nature and seriousness of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

- v. Alternative ways to manage risks, avoiding exclusion, include:
 - medical or clinical director supervision of normal contractual clinical duties
 - restricting the practitioner to certain forms of clinical duties
 - restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling
 - sick leave for the investigation of specific health problems.
- vi. In cases relating to the capability of a practitioner, consideration will be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach will be sought from PPA. If the nature of the problem and a workable remedy cannot be determined in this way, the case manager will seek to agree with the practitioner to refer the case to PPA which can assess the problem in more depth and give advice on any action necessary. The case manager will seek telephone advice from PPA when considering restriction of practice or exclusion.

6.3.3. The exclusion process

- i. The risk assessment inclusion tool (Appendix 4) must be used prior to any action taken about whether to exclude/redeploy/restrict/amend the duties of any practitioner.
- ii. Key features of exclusion from work:
 - an initial *immediate* exclusion of no more than two weeks if warranted
 - notification of PPA before formal exclusion
 - formal exclusion (if necessary) for periods up to four weeks
 - advice on the case management plan from PPA
 - appointment of a Board member to monitor the exclusion and subsequent action
 - referral to PPA for formal assessment if part of case management plan
 - active review to decide renewal or cessation of exclusion
 - a right to return to work if review not carried out
 - performance reporting on the management of the case
 - programme for return to work if not referred to disciplinary procedures or performance assessment.
- iii. The Trust will not exclude a practitioner for more than four weeks at a time without a review (see Section 6.3.5 for details of immediate

exclusion). The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Key officers and the Trust Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

6.3.4. Roles of officers

- i. The Trust Chief Executive has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by persons nominated under paragraph 6.3.4.iii.
- ii. The case will be discussed fully with the Chief Executive, the Medical Director, the Director of People and OD, MDAG, PPA and other interested parties (such as the police where there are serious criminal allegations, the Counter Fraud & Security Management Service or Safeguarding Children or Adults representatives) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.
- iii. The authority to exclude a member of staff is vested in:
 - the Chief Executive or his/her deputy
 - the Medical Director or his/her deputy
 - the Director of People and OD and his/her deputy
- iv. The Medical Director will act as the case manager in the case of consultant staff, or delegate this role to a senior medical manager to oversee the case, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member. The investigating officer will provide factual information to assist the case manager in reviewing the need for exclusion and making progress reports to the Chief Executive and Designated Board member.

6.3.5. Immediate exclusion

- i. In exceptional circumstances an immediate time-limited exclusion may be necessary, for the purposes identified in paragraph 6.3.2.iii above, following:
 - a critical incident when serious allegations have been made, or
 - where there has been a significant breakdown in relationships between a colleague and the rest of the team, or
 - where the presence of the practitioner is likely to hinder the investigation
 - where the presence of the practitioner may give rise to the risk of destruction or contamination of evidence or interference with witnesses.
- ii. Such exclusion will allow a more measured consideration to be undertaken and PPA should be contacted before the immediate

exclusion takes place. This period should be used to carry out a preliminary situation analysis, to seek further advice from PPA and to convene a case conference.

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

6.3.6. Formal exclusion

- i. A formal exclusion may only take place after the case manager has first considered whether there is a potential case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. PPA must be consulted where formal exclusion is being considered. This should be informed by the fact finding report (see 6.1.1.) and completion of the risk assessment exclusion tool at Appendix 4.
- ii. The fact finding report should provide sufficient information for a decision to be made as to whether:
 - the allegation appears unfounded, or
 - there is a potential misconduct issue, or
 - there is a concern about the practitioner's capability, or
 - the complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be enquired into.
- iii. Formal exclusion of one or more clinicians must only be used where:
 - there is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:
 - ❖ allegations of misconduct
 - ❖ concerns about serious dysfunctions in the operation of a clinical service
 - ❖ concerns about lack of capability or poor performance of sufficient seriousness that is warranted to protect patients, or
 - the presence of the practitioner(s) in the workplace is likely to hinder the investigation.
- iv. Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

- v. When the practitioner is informed of the exclusion, there should be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (eg: further training, referral to Occupational Health, referral to PPA with voluntary restriction).
- vi. The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state:
 - the effective date and time
 - duration (up to four weeks)
 - the content of the allegations
 - the terms of the exclusion (eg: exclusion from the premises - see section 6.3.7
 - the need to remain available for work - paragraph 6.3.8.ii), and
 - that a full investigation or what other action will follow.

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

- vii. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week renewable periods until the completion of disciplinary procedures if a return to work is considered inappropriate. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, as soon as the original reasons for exclusion no longer apply.
- viii. If the case manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example, because of a police investigation), the case must be referred to PPA for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period, the principle of four-week "renewability" must be adhered to.
- ix. If, at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

6.3.7. Exclusion from premises

- i. Practitioners will not be automatically barred from the premises upon exclusion from work. The case manager must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence or where the practitioner may be a serious potential danger to patients or other staff. In other circumstances, however, there may be no reason to exclude the practitioner from the premises.
- ii. Where a practitioner is barred from the premises, the MD will decide whether this exclusion extends to remote access to the hospital IT network, or whether specific exclusions should be applied (eg a requirement not to contact or email witnesses).
- iii. Exclusion from premises and the IT network should only be used in exceptional circumstances and must be clearly justified, with arrangements made to ensure the excluded practitioner has access to any resources needed to help in their defence.

6.3.8. Keeping in contact and availability for work

- i. The practitioner should normally be allowed to retain contact with colleagues, take part in clinical audit and remain up to date with developments in their field of practice or undertake research or training.
- ii. Exclusion under this procedure will be on full pay therefore the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continue undertaking such work or to take annual leave or study leave. The practitioner should be reminded of these contractual obligations but should be given 24 hours' notice to return to work. In exceptional circumstances the case manager may decide that payment is not justified because the practitioner is no longer available for work (eg: abroad without agreement).
- iii. The case manager should make arrangements to ensure that the practitioner can keep in contact with colleagues on professional developments and take part in Continuing Professional Development (CPD) and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

6.3.9. Informing other organisations

- i. In cases where there is concern that the practitioner may be a danger to patients, the Trust may consider that it has an obligation to inform such other organisations, including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it.

Details of other employers (NHS and non-NHS) should be readily available from job plans but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body as the paramount interest is the safety of patients. Where an NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

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

6.3.10. Informal exclusion

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

6.3.11. Keeping exclusions under review

6.3.11.1. Informing the Board

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

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

6.3.11.2. Regular review

- i. The case manager must review the exclusion before the end of each four-week period and report the outcome to the Chief Executive and the Board. This report is advisory and it would be for the case manager to decide on the next steps as appropriate.
- ii. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon his/her employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion.
- iii. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

- iv. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.
- v. The Trust must take review action before the end of each four-week period. After three exclusions, PPA must be called in. The information below outlines the activities that must be undertaken at different stages of exclusion.
- vi. The Trust will use the same timeframes to review any restrictions on practice that have been placed on a practitioner, although the requirements for reporting to the Board and NHS Improvement do not apply in these circumstances.
- vii. It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the Designated Board Member should be involved to any significant degree in each review.

6.3.11.3. First and second reviews (and reviews after the third review)

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

- The case manager decides on next steps as appropriate, taking into account the views of the practitioner. Further renewal may be for up to four weeks.
- The case manager submits an advisory report of outcome to the Chief Executive and Trust Board.
- Each renewal is a formal matter and must be documented as such.
- The practitioner must be sent written notification on each occasion.

6.3.11.4. Third review

If the practitioner has been excluded for three periods:

- a report must be made to the Chief Executive outlining the reasons for the continued exclusion, why restrictions on practice would not be an appropriate alternative and, if the investigation has not been completed, a timetable for completion of the investigation
- the Chief Executive must report to NHS Improvement (see vii below) and the Designated Board Member (see viii below)
- the case must formally be referred to PPA explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion at the earliest opportunity

6.3.11.5. Six-month review

- i. If the exclusion has been extended over six months:
 - a further position report must be made by the Chief Executive to NHS Improvement indicating the reason for continuing the exclusion, the anticipated time scale for completing the process and the actual and anticipated costs of exclusion
 - PPA and /or NHS Improvement will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can offer to the Board.
- ii. There will be a normal maximum limit of six months' exclusion except for those cases involving criminal investigation of the practitioner concerned. The Trust and PPA will actively review such cases at least every six months.

6.3.11.6. Appeal

At any stage when a practitioner is excluded or has restrictions placed on their practice, they may appeal to a panel convened by the Trust. Once an appeal has been heard, the practitioner will not be allowed to appeal again for a period of three months. The panel will consist of a Trust Executive Director appointed by the Medical Director (to chair the panel), a consultant appointed by the SMADEC and a third member from the same specialty and grade as the suspended practitioner from outside the Trust. The panel will recommend to the Chief Executive whether the exclusion or restriction should continue or be lifted.

6.3.11.7. The role of the Board and Designated Member

- i. The Board is responsible for designating one of its non-executive members as a Designated Board member under these procedures. The Designated Board member is the person who oversees the case manager and case investigator during the investigation process and maintains momentum of the process.
- ii. This member's responsibilities include:
 - receiving reports and reviewing the continued exclusion from work
 - considering representations from the practitioner about his/her exclusion
 - considering any representations about the investigation.
- iii. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the Designated Board member should be involved to any significant degree in each review.

6.3.11.8. Return To Work

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

6.4. Part 3: Process for dealing with conduct hearings

6.4.1. Introduction

- i. Cases which solely involve allegations of misconduct against medical or dental staff will be dealt with, as for all other staff groups, under the Trust's *Disciplinary Policy and Procedure* (a copy of which is available from the HR folder in the document library) but only after the procedure for investigating allegations of misconduct referred to in this policy have been undertaken. However, where any concerns about the conduct of a medical or dental practitioner are raised, the Trust will contact the Practitioner Performance Advice (PPA) for advice before proceeding.
- ii. Where the alleged misconduct being investigated under the Trust's *Disciplinary Policy and Procedure* relates to matters of a professional nature, the case investigator must obtain appropriate independent professional advice.
- iii. When a report of the conduct investigation has been received, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments.
- iv. Similarly, where a case involving issues of professional conduct proceeds to a hearing under the Trust's *Disciplinary Policy and Procedure*, the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.
- v. The Trust will work with the relevant university or NHS organisation to ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts.
- vi. The Trust's *Disciplinary Policy and Procedure* sets out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". These will generally fall into four distinct categories:
 - a refusal to comply with reasonable requirements of the Trust
 - an infringement of the Trust's disciplinary rules including conduct that contravenes the standard of professional behaviour required of doctors and dentists by their regulatory body

- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct
 - wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care, patient safety or create serious dysfunction to the effective running of a service.
- vii. Examples of issues that should be investigated under the Capability Procedure are set out in paragraph 6.5.1.iv.
- viii. Any allegation of misconduct against a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the Postgraduate Dean from the outset.
- ix. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities, may come into this category. Additionally, instances of failing to give proper support to other members of staff, including doctors or dentists in training, may be considered in this category.
- x. The Trust, having consulted PPA and the Director of People and OD or nominated deputy will decide upon the most appropriate way forward.
- xi. If a practitioner considers that the case has been wrongly classified as misconduct, he/she (or his/her representative) is entitled to use the Trust's *Grievance and Disputes Policy and Procedure*. Alternatively, or in addition, he/she may make representations to the Designated Board member.

6.4.2. Action when investigations identify possible criminal acts

- i. Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The Trust investigation (under its Disciplinary Policy and Procedure) will only proceed in respect of those aspects of the case which are not directly related to the police investigation underway. The Trust will consult the police to establish whether an investigation into any other matters would impede their investigation.
- ii. In any case where fraud (as defined by the Fraud Act 2006 or Theft Act 1968) is suspected, the matter shall be reported to the Trust's Local Counter Fraud Specialist immediately. Further information can be obtained from the trust's Counter Fraud and Corruption against the NHS policy.
- iii. It is important that any investigation conducted by the Trust does not interfere with any evidence that may be used to resolve any suspicion of criminal wrongdoing. Equally, the Trust recognises that investigations conducted by any law enforcement body are outside of the control of the Trust and operate under their own processes which may differ to those of

the Trust. This may mean that parallel investigations run concurrently. There is no set order in which aspects of each investigation should occur; they should be decided on a case by case basis between the investigators involved.

6.4.3. Cases where criminal charges are brought not connected with an investigation by Royal Cornwall Hospitals NHS Trust

- i. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, the Trust, having considered the facts, will need to consider whether the practitioner poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner.
- ii. The Trust will have to give serious consideration to whether the practitioner can continue in their job once criminal charges have been made. Bearing in mind the presumption of innocence, the Trust will consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the practitioner can continue in their present job, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice will be sought from the MD, Director of People and OD and/or the Trust's legal adviser. The Trust will explain the reasons for taking any such action to the practitioner concerned.

6.4.4. Dropping of charges or no court conviction

- i. When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but the Trust feels there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to ensure that the individual concerned does not pose a risk to patient safety.
- ii. Similarly, where there are insufficient grounds for bringing charges, or the court case is withdrawn, there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide, and is used in the Trust's case, will have to be made available to the doctor or dentist concerned.
- iii. Where charges are dropped, the presumption is that the practitioner will be reinstated.

6.4.5. Terms of settlement on termination of employment

- i. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following principles will be used by the Trust in such circumstances.
 - Settlement agreements must not be to the detriment of patient safety.

- It is not acceptable to agree any settlement that precludes either appropriate investigations being carried out and reports made or referral to the appropriate regulatory body.
- Payment will not normally be made when a practitioner's employment is terminated on disciplinary grounds or following their resignation.
- Expenditure on termination payments must represent value for money. The Trust would need to demonstrate why the severance payment is in the public interest, how it represents value for money and how it represents the best use of public funds. The matter would need to be considered and agreed by the Trust's Remuneration Committee and NHS Improvement prior to submission to HM Treasury for approval. A clear record must be kept, setting out the calculations, assumptions and rationale of all decisions taken to show that the Trust or authority has taken into account all relevant factors including legal advice.
- Offers of compensation, as an inducement to secure the voluntary resignation of an individual, must not be used as an alternative to the disciplinary process.
- All job references must be accurate, realistic and comprehensive and, under no circumstance, may they be misleading.
- Where a termination settlement is agreed, details may be confirmed in a Settlement Agreement that should set out what each party may say in public or write about the settlement. The Settlement Agreement is for the protection of each party. It should comply with NHS Employers' guidance on the use of such agreements and must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an *open reference*. For the purposes of this paragraph, an *open reference* is one that is prepared in advance of a request by a prospective employer.

6.5. Part 4. Procedure for dealing with issues of capability

6.5.1. Introduction and general principles

- i. There will be occasions where the Trust considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as *capability issues*. Matters that should be described and dealt with as misconduct issues are covered in Section 6.4 of this procedure.
- ii. Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from PPA will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management,

the matter must be referred to PPA before the matter can be considered by a capability panel (unless the practitioner refuses to have his or her case referred).

- iii. No member of the capability panel or advisers to the panel should have been previously involved in carrying out an investigation.
- iv. Matters which fall under the Trust's capability procedures include:
 - out of date clinical practice
 - inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk
 - incompetent clinical practice
 - inability to communicate effectively with colleagues and/or patients
 - inappropriate delegation of clinical responsibility
 - inadequate supervision of delegated clinical tasks
 - ineffective clinical team working skills.

This is not an exhaustive list.

- v. Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through on-going assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. PPA will be consulted for advice to support the remediation of a doctor or dentist. Placement in clinical teams outside the Trust may be considered where there is conflict of interest within a team or there has been a loss of confidence in the working relationship.

6.5.2. How to proceed where conduct and capability issues are involved

- i. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. The decision as to which process should be initiated shall be taken by the Case Manager in conjunction with the Director of People and OD and PPA.
- ii. The practitioner is also entitled to use the Trust's grievance procedure if they consider that the case has been incorrectly classified. Alternatively, or in addition, he/she may make representations to the Designated Board member.

6.5.3. Duties of Employers

- i. The procedures set out below are designed to cover issues where a doctor's or dentist's capability to practice is in question. Prior to instigating these procedures, the Trust will consider the scope for

resolving the issue through counselling or retraining and will take advice from PPA.

- ii. The Trust will work with the relevant university to ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts.
- iii. Capability may be affected by ill health and this will be considered in any investigation. Arrangements for handling concerns about a practitioner's health are described in Section 6.6 of this procedure.
- iv. The Trust will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of age, disability, gender/gender identity/gender re-assignment, marital status/civil partnership, maternity/pregnancy, race, religion/belief or sexual orientation.
- v. The Trust will ensure that managers and case investigators receive appropriate and effective training in the operation of this procedure. Those undertaking investigations or sitting on capability or appeal panels must have had formal equality and inclusion training before undertaking such duties. The Trust Board will agree what training staff and Board members must have completed before they can take a part in these proceedings.

6.5.4. Capability procedure: the pre-hearing process

- i. When a report of the capability investigation has been received the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.
- ii. The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of PPA. The case manager will need to consider urgently whether:
 - action under Section 6.3 of the procedure is necessary to exclude the practitioner, or
 - to place temporary restrictions on their clinical duties.
- iii. The case manager will also need to consider, with the Medical Director and Director of People and OD, whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to PPA for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The case manager will inform the practitioner concerned of the

decision as soon as possible and normally within 10 working days of receiving the practitioner's comments.

- iv. PPA will assist the Trust in drawing up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by PPA but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by PPA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.
- v. If the practitioner does not agree to the case being referred to PPA, a panel hearing will normally be necessary.
- vi. If a capability hearing is to be held, the following procedure will be followed beforehand.
 - The case manager must notify the practitioner in writing of the decision to arrange a capability hearing at least 20 working days in advance. Notification must include details of the allegations and the arrangements for proceeding, including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so choose.
 - All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the Trust will consider whether a new date should be set for the hearing.
 - Should either party request a postponement to the hearing, the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not less than 30 working days), to proceed with the hearing in the practitioner's absence although the Trust will act reasonably in deciding to do so, taking into account any comments made by the practitioner.
 - Should the practitioner's ill health prevent the hearing from taking place the Trust will implement its usual absence procedures and involve the Occupational Health department as necessary.
 - Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing. Following representations from either side contesting a

witness statement which is to be relied upon in the hearing, the Chairman will invite the witness to attend. The Chairman cannot require anyone other than a staff member to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel will reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.

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

6.5.5. The hearing framework

- i. The capability hearing will be chaired by an Executive Director of the Trust. The panel will comprise a total of three people, normally two members of the Trust Board or senior staff, appointed by the Board, for the purpose of the hearing. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust. The Trust will agree the external medical or dental member with the Chair of the LNC/SMADEC.
- ii. Arrangements must be made for the panel to be advised by:
 - a senior member of staff from Human Resources, and
 - a senior clinician from the same or similar clinical specialty as the practitioner concerned but from another NHS employer.
- iii. It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.
- iv. It is for the Trust to ultimately decide upon the membership of the panel. The practitioner may raise an objection to the choice of any panel member within five working days of notification. The Trust will review the situation and will respond in writing prior to the hearing stating the reasons for any decisions on the objections. The Trust will take all reasonable measures to ensure that the membership of the panel is acceptable to the practitioner and, exceptionally, it may be necessary to postpone the hearing while this matter is resolved.

6.5.6. Representation at capability hearings

- i. The practitioner will be given every reasonable opportunity to present his/her case although the hearing should not be conducted in a legalistic or excessively formal manner.
- ii. Practitioners have the right to be represented and/or accompanied by an official or lay representative of their professional organisation or defence organisation, a work colleague or a friend, partner or spouse. Where any

of the above are legally qualified they will not be able to act in a legal capacity.

- iii. 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.

6.5.7. Capability hearing

The hearing should be conducted as follows:

- the Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing
- the panel and its advisers (see paragraph 6.5.5.ii), the practitioner, his/her representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire
- the procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:
 - ❖ the side calling the witness can question the witness
 - ❖ the other side can then question the witness
 - ❖ the panel may question the witness
 - ❖ the side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence
- the order of presentation shall be:
 - ❖ the case manager presents the management case including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave
 - ❖ the Chairman shall invite the case manager to clarify any matters arising from the management case on which the panel requires further clarification
 - ❖ the practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave
 - ❖ the Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification
 - ❖ the Chairman shall invite the case manager to make a brief closing statement summarising the key points of the case
 - ❖ the Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation

- ❖ the panel shall then retire to consider its decision.

6.5.8. Decisions

- i. The panel will have the power to make a range of decisions including the following:
 - no action required
 - oral agreement that there must be an improvement in clinical performance within a specified time-scale with a written statement of what is required and how it might be achieved [stays on the practitioner's record for six months]
 - written warning that there must be an improvement in clinical performance within a specified time-scale with a statement of what is required and how it might be achieved [stays on the practitioner's record for one year]
 - final written warning that there must be an improvement in clinical performance within a specified time-scale with a statement of what is required and how it might be achieved [stays on the practitioner's record for one year]
 - termination of contract.

Note: It is also reasonable for the panel to make comments and recommendations on issues, other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the Trust that the panel wishes to comment upon.

- ii. A record of oral agreements and written warnings should be kept on the practitioner's personnel file with the duration of any warning explicitly documented.
- iii. Because of the complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing. Where this is impractical the panel has discretion to make alternative arrangements. However, the decision of the panel will be communicated to both parties as soon as possible and normally within five working days of the hearing.
- iv. The decision must be confirmed in writing to the practitioner. This notification must include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

6.5.9. Capability appeals procedure

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

- a fair and thorough investigation of the issue
 - sufficient evidence arising from the investigation or assessment on which to base the decision
 - whether, in the circumstances, the decision was fair and reasonable, and commensurate with the evidence heard.
- ii. It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not rehear the case in its entirety (but in certain circumstances it may order a new hearing see 6.5.10.i).
- iii. A dismissed practitioner will potentially be able to take their case to an Employment Tribunal where the reasonableness of the Trust's actions can be tested.

6.5.10. The appeal process

- i. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the capability hearing or order that the case is reheard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chair of the panel shall have the power to instruct a new capability hearing.
- ii. Where the appeal is against dismissal, the practitioner should not be paid during the appeal if it is heard after the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to rehear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

6.5.11. The appeal panel

- i. The panel will consist of three members. The members of appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the Designated Board member. These members will be:
- an independent member (trained in legal aspects of appeals) from an approved pool. This person will be appointed from the national list held by NHS Employers for this purpose. This person will act as Chair
 - the Trust's Chair (or other non-executive director of the Trust) who must have the appropriate training for hearing an appeal
 - a medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust who must also have the

appropriate training for hearing an appeal. The Trust will agree the external medical or dental member with the Chair of the JLNC/SMADEC.

- ii. The panel should call on others to provide specialist advice. This may include:
 - a consultant from the same specialty or sub-specialty as the appellant but from another NHS employer. Where the case involves a dentist this may be a consultant or an appropriate senior practitioner
 - a senior Human Resources specialist who may be from another NHS organisation.
- iii. It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If, for any reason, the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.
- iv. The Trust should make the arrangements for the panel and notify the appellant as soon as possible and, in any event, within the recommended timetable in paragraph 6.5.11.vi. The practitioner may raise an objection to the choice of any panel member within five working days of notification. The Trust will review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner.
- v. It may be necessary to postpone the hearing while this matter is resolved. The Trust must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.
- vi. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability hearing. The following timetable will apply in all cases:
 - appeal by written statement, giving full grounds for the appeal, to be submitted to the designated appeal point (normally the Director of People and OD) within 25 working days of the date of the written confirmation of the original decision
 - hearing to take place within 25 working days of date of lodging appeal
 - decision reported to the appellant and the Trust within five working days of the conclusion of the hearing.
- vii. The timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The case manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

6.5.12. Powers of the appeal panel

- i. The appeal panel has the right to call witnesses of its own volition but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.
- ii. Exceptionally, where during the course of the hearing, the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing re-assembles.
- iii. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal or whether the case should be reheard, on the basis of the new evidence, by a capability hearing panel.

6.5.13. Conduct of appeal hearing

- i. All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence.
- ii. The practitioner may be represented and/or accompanied by an official or lay representative of their professional organisation or defence organisation, a work colleague or a friend, partner or spouse. Where any of the above are legally qualified they will not be able to act in a legal capacity (see Section 1.4). 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.
- iii. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can, at this stage, make a statement in mitigation.
- iv. The panel, after receiving the views of both parties, shall consider and make its decision in private.

6.5.14. Decision

- i. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's case manager such that it is received within five working days of the conclusion of the hearing.
- ii. The decision of the appeal panel is final and binding.

- iii. There shall be no correspondence on the decision of the panel except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

6.5.15. Action following hearing

- i. Records must be kept, including a report detailing the capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it.
- ii. These records must be kept confidential and retained in accordance with the capability procedure and the *Data Protection Act 2018 (enacting the General Data Protection Regulations)*. These records need to be made available to those with a legitimate call upon them such as the practitioner, the regulatory body or in response to a direction from an Employment Tribunal.

6.5.16. Termination of employment with performance issue unresolved

- i. Where a practitioner leaves employment before procedures have been completed, any outstanding disciplinary investigation will be concluded and capability proceedings will be completed where possible whatever the personal circumstances of the employee concerned.
- ii. Where employment ends before investigation or proceedings have been concluded, every reasonable effort will be made to ensure the former practitioner remains involved in the process. If contact with the practitioner has been lost, the Trust will invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The Trust will make a judgement, based on the evidence available, as to whether the allegations about the practitioner's capability are upheld. If the allegations are upheld, the Trust will take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, referral to the Local Authority Designated Officer (LADO) and the Disclosure and Barring Service.
- iii. If an excluded practitioner or a practitioner facing capability proceedings becomes ill, they will be subject to the Trust's *Attendance Management Policy and Procedure*. The sickness absence procedures take precedence over the capability procedures and the Trust will take reasonable steps to give the practitioner time to recover and attend any hearing. Where the practitioner's illness exceeds four weeks (or immediate if their absence is stress related) they must be referred to the Occupational Health department. The Occupational Health department will advise the Trust on the expected duration of the illness and any consequences it may have for the capability process and will also be able to advise on the practitioner's capacity for future work, as a result of which the Trust may wish to consider retirement on health grounds. Should employment be terminated as a result of ill health, the

investigation should still be taken to a conclusion and the Trust form a judgement as to whether the allegations are upheld.

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

6.6. Part 5. Handling concerns about a practitioner's health

6.6.1. Introduction

- i. A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress.
- ii. The Trust's key principle for dealing with individuals with health problems is that wherever possible, and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment rather than be lost from the NHS.

6.6.2. Retaining the services of individuals with health problems

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

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

This is not an exhaustive list.

6.6.3. Reasonable adjustment

- i. At all times the practitioner will be supported by the Trust and the Occupational Health (OH) department which will ensure that the practitioner is offered every reasonable resource available to get back to practice where appropriate. The Trust will consider what reasonable adjustments could be made to their workplace or other arrangements, in line with the Equality Act 2010. In particular, it will consider:
 - making adjustments to the premises
 - re-allocating some of a disabled person's duties to another
 - transferring a practitioner to an existing vacancy
 - altering a practitioner's working hours or pattern of work
 - assigning the practitioner to a different workplace

- allowing absence for re-habilitation, assessment or treatment
 - providing additional training or re-training
 - acquiring/modifying equipment
 - modifying procedures for testing or assessment
 - providing a reader or interpreter
 - establishing mentoring arrangements.
- ii. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner. However, any issues relating to conduct or capability that have arisen will be resolved using the appropriate agreed procedures.

6.6.4. Handling health issues

- i. Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine a health problem. If the report recommends OH involvement, the nominated clinical manager, with the support of the Care Group HR practitioner, must immediately refer the practitioner to a qualified occupational physician (usually a consultant) with the Occupational Health department.
- ii. PPA should be approached to offer advice on any situation and at any point where the Trust is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.
- iii. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of People and OD, the Medical Director or case manager, the practitioner and case worker from OH to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.
- iv. If a doctor or dentist's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work and referral to the professional regulatory body must be considered, irrespective of whether or not they have retired on the grounds of ill health.
- v. In those cases where there is impairment of performance solely due to ill health, disciplinary procedures will be considered only in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the Trust to resolve the underlying situation, eg by repeatedly refusing a referral to OH or PPA. In these circumstances the procedures in Section 6.5 should be followed.

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

7. Dissemination and Implementation

7.1. A copy of the policy will be stored electronically in the Human Resources/Medical Staffing section of the Trust's document library on the internet/intranet site.

7.2. A copy of the policy will be circulated to the Heads of HR and HR Practitioners to enable them to participate in and support the implementation of the policy.

7.3. A clear communication will be sent to the Trust's senior managers, including the Medical Director and other executive directors, to make them aware that the new policy has been issued and that they are responsible for cascading the information to the clinical line managers they are responsible for.

7.4. The Chairs of the JLNC and SMADEC will be advised of the issue of the revised policy.

8. Monitoring compliance and effectiveness

| | |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Element to be monitored | <ul style="list-style-type: none"> ▪ Number of cases being managed in accordance with MHPS and/or Trust Disciplinary Policy and Procedure. ▪ Number of exclusions ▪ Number of referrals made to PPA. ▪ Number of referrals made to GMC/GDC. |
| Lead | Director of People and OD Medical Director |
| Tool | HR medical and dental case log |
| Frequency | Monthly |
| Reporting arrangements | Medical Directors Advisory Group (MDAG), POD |
| Acting on recommendations and Lead(s) | The Director of People and OD, in conjunction with the Medical Director, will be responsible for ensuring that appropriate recommendations are acted upon within reasonable time-frames. |
| Change in practice and lessons to be shared | Required changes in practice and lessons to be shared will be identified and actioned within three months. A lead member of the team will be identified to take each change forward as appropriate. Lessons will be shared with all the relevant stake-holders. |

9. Updating and Review

9.1. The policy will be reviewed no less than every three years.

9.2. This procedure may be amended earlier to reflect any future national advice or guidance but only by agreement with the JLNC. Where there is any conflict or lack of clarity the existing nationally agreed guidance will take precedence.

9.3. The operation of the procedure in practice will be reviewed regularly as it is deployed and where operational issues arise that potentially require a revision of the provisions.

9.4. Where early revisions are significant and the overall policy is changed, the revised policy will be taken through the standard consultation, approval and dissemination processes. Where early revisions are minor, e.g. amended job titles or changes in organisational structure, approval will be sought from the Executive Director responsible for signatory approval so that the policy can be amended and the changes reported without the need for full consultation.

10. Equality and Diversity

10.1. The Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance information

| | | | |
|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------|
| Document Title | Maintaining High Professional Standards in the Modern NHS Policy V2.0 | | |
| Date Issued/Approved: | July 2019 | | |
| Date Valid From: | July 2019 | | |
| Date Valid To: | July 2022 | | |
| Directorate / Department responsible (author/owner): | Human Resources | | |
| Contact details: | 01872 252649 | | |
| Brief summary of contents | An outline of the Trust's procedure for handling concerns about doctors' and dentists' conduct and capability. | | |
| Suggested Keywords: | | | |
| Target Audience | RCHT ✓ | CFT | KCCG |
| Executive Director responsible for Policy: | Medical Director/Director of People and Organisational Development | | |
| Date revised: | July 2019 | | |
| This document replaces (exact title of previous version): | Maintaining High Professional Standards in the Modern NHS, V1.1 | | |
| Approval route (names of committees)/consultation: | Joint Local Negotiating Committee (JLNC) | | |
| Divisional Manager confirming approval processes | Deputy Director of People and Organisational Development | | |
| Signature of JLNC Chair Jonathan Lord | {Original Copy Signed} | | |
| Signature of Executive Director giving approval | {Original Copy Signed} | | |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet | ✓ | Intranet Only |
| Document Library Folder/Sub Folder | Human Resources / Medical Staffing | | |
| Links to key external standards | CQC Regulation 18 - Staffing | | |
| Related Documents: | <ul style="list-style-type: none"> ▪ Attendance Management Policy ▪ Counter Fraud and Corruption Policy ▪ Dignity at Work Policy | | |

| | |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | <ul style="list-style-type: none"> ▪ Disciplinary Policy and Procedure ▪ Equality, Inclusion and HR Policy ▪ Equality Act 2010 ▪ Freedom to Speak Up; Raising Concerns (Whistleblowing) ▪ Grievance and Disputes Policy & Procedure ▪ Guidance for responding to allegations or concerns about child abuse perpetuated by health professionals and ancillary staff working in the NHS Trusts. ▪ Safeguarding Adult policy ▪ Incident and serious incident policy ▪ Maintaining High Professional Standards in the Modern NHS (DoH, 2005) ▪ Management of Work-Related Stress Policy ▪ Mentoring and Coaching Policy ▪ Supporting Staff Involved in an Incident, Complaint or Claim |
| Training Need Identified? | Yes - case investigators |

Version Control Table

| Date | Version No | Summary of Changes | Changes Made by (Name and Job Title) |
|--------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Nov 2006 | V1.0 | Initial Issue | |
| October 2015 | V1.1 | Re-formatted in line with Trust's policy template. | Ray Sinclair Helen Strickland and Gillian Stratton HR Business Partners |
| July 2019 | V2.0 | Summary flowchart updated. Section 1 - information added re counter fraud Section 4 - Definitions updated. Section 5 - Ownership - duties updated, new section on MDAG. Section 6 - 6.1 Initial procedure clarified and updated. 6.2.1 addition of new sections on: safeguarding and counter fraud 6.2.2 Introduction of the exclusion risk assessment tool 6.2.4 Inclusion of terms of reference 6.2.7. New section on staff support 6.2.8. New section on overlapping employment relations issues and introduction | HS/RS/ FK/GD |

| | | | |
|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| | | <p>6.3.7 Additional paragraphs on exclusion from premises</p> <p>6.4.2. Additional information on counter fraud</p> <p>6.4.5. Updated settlement agreement section</p> <p>6.5.8. Updated decisions' section</p> <p>General updates:</p> <ul style="list-style-type: none"> ▪ Job titles ▪ Organisation titles eg NCAS now PPA ▪ NHSI ▪ Updates to Appendices 1 and 2 ▪ Introduction of Appendix 6 – Summary of Rights. | |
|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Initial Equality Impact Assessment Form

| | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------|------------------------|-------|
| <i>Name of the strategy / policy / proposal / service function to be assessed</i> Maintaining High Professional Standards in the Modern NHS Policy V2.0 | | | | | | |
| Directorate and service area: Human Resources/Medical Staffing | | | Is this a new or existing Policy? Existing | | | |
| Name of individual completing assessment: Helen Strickland | | | Telephone: 01872 252649 | | | |
| 1. <i>Policy Aim*</i> <i>Who is the strategy / policy / proposal / service function aimed at?</i> | | To ensure the Trust has an open, fair and transparent process in place for handling concerns about the conduct and performance of medical and dental employees. | | | | |
| 2. <i>Policy Objectives*</i> | | .To provide guidance on: <ul style="list-style-type: none"> • dealing with initial concerns about practitioners (informal process) • procedures for considering whether there is a need for exclusions or restrictions on practice • conduct/capability/ill-health concerns. | | | | |
| 3. <i>Policy – intended Outcomes*</i> | | To ensure all concerns are dealt with fairly and equitably in accordance with the procedures set out in this document. Improved conduct, organisational culture and demonstrable learning from disciplinary events. | | | | |
| 4. <i>*How will you measure the outcome?</i> | | See Section 8 of the policy “Monitoring Compliance and Effectiveness”. | | | | |
| 5. <i>Who is intended to benefit from the policy?</i> | | Patients, practitioners and the Trust | | | | |
| 6a <i>Who did you consult with</i> | | Workforce | Patients | Local groups | External organisations | Other |
| | | ✓ | | | | |
| b). <i>Please identify the groups who have been consulted about this procedure.</i> | | Please record specific names of groups <ul style="list-style-type: none"> ▪ JLNC ▪ Policy Review Group | | | | |
| What was the outcome of the consultation? | | No concerns identified. | | | | |

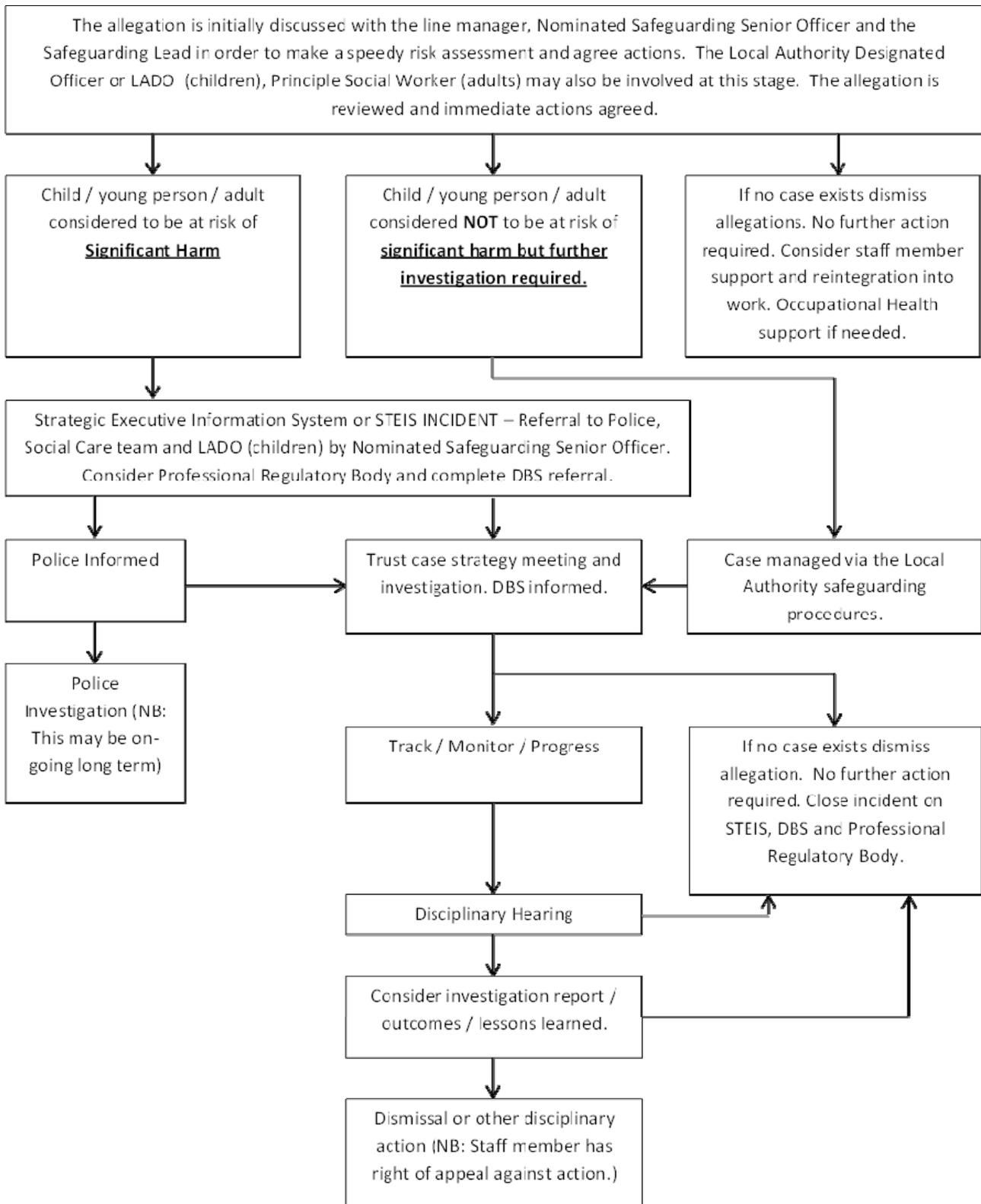
| 7. The Impact | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|--------|----------------------------------------------------------------------------------------------------------------------------------|--|-----------|---|
| Please complete the following table. | | | | | | | |
| Are there concerns that the policy could have differential impact on: | | | | | | | |
| Equality Strands: | Yes | No | Unsure | Rationale for Assessment / Existing Evidence | | | |
| Age | | ✓ | | | | | |
| Sex (male, female, trans-gender / gender reassignment) | | ✓ | | | | | |
| Race / Ethnic communities /groups | | ✓ | | | | | |
| Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions. | | ✓ | | Policy specifically refers to and makes provision for the consideration of all reasonable adjustments for staff who are disabled | | | |
| Religion / other beliefs | | ✓ | | | | | |
| Marriage and Civil partnership | | ✓ | | | | | |
| Pregnancy and maternity | | ✓ | | | | | |
| Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian | | ✓ | | | | | |
| <p>You will need to continue to a full Equality Impact Assessment if the following have been highlighted:</p> <ul style="list-style-type: none"> You have ticked "Yes" in any column above and No consultation or evidence of there being consultation- this <u>excludes</u> any <i>policies</i> which have been identified as not requiring consultation. or Major this relates to service redesign or development | | | | | | | |
| 8. Please indicate if a full equality analysis is recommended. | | | | Yes | | No | ✓ |
| 9. If you are not recommending a Full Impact assessment please explain why. | | | | | | | |
| No issues of concern were identified. | | | | | | | |

| | | | |
|-----------------------------------|-----------|----------------------------------------|---------------------------------------|
| Date of completion and submission | July 2019 | Members approving screening assessment | Policy Review Group (PRG) APPROVED |
|-----------------------------------|-----------|----------------------------------------|---------------------------------------|

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust's web site.

Appendix 3. Managing Safeguarding Allegations



Appendix 4. Risk assessment - exclusion

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RISK ASSESSMENT – EXCLUSION

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

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

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

- the Chief Executive or his/her deputy
- the Medical Director or his/her deputy
- the Director of People and OD or his/her deputy.

| | |
|---------------------------------------------|--|
| Date: | |
| Manager: | |
| HR Practitioner: | |
| Name of staff member: | |
| Department/directorate: | |
| Issue/incident: | |
| Reported by: | |
| Evidence obtained prior to risk assessment: | |

Risk analysis (see table below for grading)

| Risks | Yes | No | Risk Likelihood (L) | Risk Consequence (C) | Score (L x C) |
|-------------------------------|--------------------------|--------------------------|---------------------|----------------------|---------------|
| Risk of harm to patients | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of harm to employees | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of harm to self | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of harm to Trust | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of continued fraud | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk to service provision | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk to investigation process | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Some other substantial reason | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Risk grading

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

 1 – 3 Low risk  4 – 6 Moderate  8 – 12 High risk  15 – 25 Extreme risk

Maintaining High Professional Standards in the Modern NHS
Risk Assessment Form – Exclusion, V1.0
Author: Helen Strickland, HR Business Partner
Review date: January 2021

Actions to be taken to reduce risk

| Risk | Mitigation action | New Risk Rating (following implementation of mitigation action) |
|------|-------------------|-----------------------------------------------------------------------|
| | | |

Decision on outcomes following risk analysis

| Risk options | Yes | No | Reason for risk option |
|--------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|------------------------|
| No requirement to take action identified | <input type="checkbox"/> | <input type="checkbox"/> | |
| Manage the risk and allow the staff member to remain within their role under close supervision | <input type="checkbox"/> | <input type="checkbox"/> | |
| Reduce the risk and limit duties and role under supervision within the same workplace | <input type="checkbox"/> | <input type="checkbox"/> | |
| Transfer the risk and redeploy the staff member temporarily to alternative employment within the Trust | <input type="checkbox"/> | <input type="checkbox"/> | |
| Avoid the risk and exclude the staff member | <input type="checkbox"/> | <input type="checkbox"/> | |

| | |
|--------------------------|-------|
| Signed: | Date: |
| Name and job title: | |
| Signed: | Date: |
| Name of HR Practitioner: | |

Please ensure a copy of this form is retained on the investigation file.

Appendix 5. Impact assessment tool: overlapping Employee Relations processes

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IMPACT ASSESSMENT TOOL

OVERLAPPING EMPLOYEE RELATIONS PROCESSES

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

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

| | |
|--------------------------------|--|
| Current investigation details: | |
| Counter allegation details: | |

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

Risk analysis (see table below for grading)

| Risks | Yes | No | Risk Likelihood (L) | Risk Consequence (C) | Score (L x C) |
|-------------------------------|--------------------------|--------------------------|---------------------|----------------------|---------------|
| Risk of harm to patients | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of harm to employees | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of harm to self | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of harm to Trust | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk of continued fraud | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk to service provision | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Risk to investigation process | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Some other substantial reason | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Risk grading

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

1 - 3 Low risk
4 - 6 Moderate
8 - 12 High risk
15 - 25 Extreme risk

Maintaining High Professional Standards in the Modern NHS
Impact Assessment Form – Overlapping Employee Relations Processes, V1.0
Author: Helen Strickland, HR Business Partner
Review date: January 2021

Actions to be taken to reduce risk

| Risk | Mitigation action | New Risk Rating (following implementation of mitigation action) |
|------|-------------------|-----------------------------------------------------------------------|
| | | |

Decision on outcomes following risk analysis

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

| | |
|--------------------------|-------|
| Signed: | Date: |
| Name and job title: | |
| Signed: | Date: |
| Name of HR Practitioner: | |

Please ensure a copy of this form is retained on the investigation file(s).

Appendix 6. Summary of rights of a practitioner under the maintaining high professional standards for medical and dental staff.

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

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

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

2. to be advised of the details of the alleged misconduct in writing prior to the interview
3. to be told of the category of the alleged misconduct
4. entitlement to all information relating to the allegations
5. to be given on request a copy of any disciplinary action which is retained on the employees' personal file
6. to be reminded in writing of his/her right of appeal in matters classed as serious or gross misconduct.

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

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

LIST OF SUITABLE CONTACTS FOR ADVICE AND SUPPORT

- BMA Representative
Regional Richard Griffiths - Industrial Relations Officer

0117 945 3112/ rgriffiths@bma.org.uk
- BMA National Helpline - 0300 123123
- Occupational Health & Counselling Department - Telephone 01872 252770