NHS
South Central
Ambulance Service
NHS Foundation Trust

DISCIPLINE & CONDUCT POLICY

South Central Ambulance Service NHS Foundation Trust
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1. INTRODUCTION

The Trust will seek to ensure through its managers that any shortcomings of staff in relation to the duties and responsibilities of their posts or their behaviour are brought to their attention at the earliest opportunity. It is good management practice to take appropriate steps to secure a mutually acceptable remedy where possible through training or counselling

The Trust values of Teamwork, Caring, Professional and Innovation underpin everything we do to support our vision of saving lives and enabling patients to get the care they need. SCAS aims to nurture a healthy culture, based on all staff demonstrating their role-relevant values-based behaviours within their working lives. All staff are expected to model their behaviours to support SCAS with its strategic aims to become an Employer, Partner and Provider of Choice.

Staff will be informed and aware of the standards required of them and what is expected of them in terms of performance, conduct and their role in carrying out Trust policies and procedures.

Managers will support and encourage all employees to achieve and maintain the highest possible standards of performance and conduct. Where appropriate, employees are given reasonable help, advice, opportunity and time to achieve the required standards.

As a responsible employer, the Trust is keen to ensure that fair and effective arrangements are in place for dealing with disciplinary matters for employees and that current employment law and the ACAS Code of Practice is observed.

The Trust recognises three categories of misconduct:

- Minor
- Serious
- Gross

All information received and divulged throughout the Discipline and Conduct procedure is to be regarded as highly confidential to those involved in the disciplinary process and otherwise may only be used where a further and separate investigation is required as a result of allegations made during a hearing. For example, allegations of bullying, harassment or other misconduct perpetrated by another employee

Apart for exceptional circumstances, which have potentially serious implications on service delivery and/or reputation, no employee will normally be dismissed without a first warning.

Where it is stated that information will be provided in writing (on either side); this includes email – which are legally acceptable since they originate from a personal account.

2. PURPOSE & SCOPE

The purpose of this policy is to provide a clear framework for managers to deal with matters of misconduct and poor performance not due to capability which is dealt with under the Capability Policy in a fair and consistent manner in accordance with the Trust's Equal Opportunities Policy

To promote the equitable and consistent treatment of staff where breaches of discipline are alleged and to ensure that disciplinary cases are managed consistently across the Trust in a non-discriminatory, fair and timely process in line with current

legislation and employment case law.

To ensure that all members of staff are fully advised of the substance and nature of the allegations before a formal investigation is undertaken and/or disciplinary action is taken against them.

This policy applies to all SCAS employees except doctors who will be dealt with in accordance with the policy, "Maintaining High Professional Standards in the Modern NHS".

It should be noted that any incident involving SCAS vehicles must be reported to the Driving Standards Manager, who will also have a role as a specialist investigator.

In line with Trust policy, knowingly making false or malicious allegations against other Trust employees will be dealt with under this policy as gross misconduct. See Appendix 6.

3. PROCEDURE

Please see to the flow chart on Appendix 9 for the appropriate procedure to be undertaken

4. EQUALITY STATEMENT

The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post, The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of the aforementioned protected characteristics whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.

By committing to a policy encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

Where there are barriers to understanding, eg, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the HR Department.

5. LEVELS OF AUTHORITY

Details of the levels of authority to take appropriate action are shown in the best practice guide for investigations & suspension

6. STAGES OF THE POLICY

The initial stage is very important in the effective implementation of a policy focussing on the improvement and maintenance of high standards of conduct. The intention should always be to gain a full understanding of the situation and to resolve an issue at the earliest opportunity and wherever possible a resolution should be sought through an informal process.

6.1 **Informal stage**
This would normally be in circumstances where performance or behaviour falls short of the required standard or could be considered as minor misconduct. In this situation, the manager would establish the facts of the situation and make a decision as to whether it is appropriate to deal with the matter informally or whether the formal disciplinary process needs to be invoked. The manager/team leader/shift supervisor should have an informal discussion about the key points, objectives and measures set and a review process (see Appendix 2). It is important that the employee is reminded of the standard of conduct or behaviour that is expected and the consequences if improvement is not achieved. Informal action could also involve close supervision, coaching, monitoring, or training with the aim of improving the standard of behaviour

6.2 To ensure the consistent application and approach across the organisation, HR can provide guidance at this stage

6.3 If the manager considers it reasonable to do so in the circumstances, they may issue the employee an **improvement notes** to ensure clarity on the conduct issue, the action required of both the employee and the manager, including details of the improvement required and the timescale. NB Informal warnings are not issued – an improvement note should be issued. A template Improvement Note is shown in the Toolkit Appendix 10. It is important that during the monitoring period, the manager ensures the provision of day-to-day supervision and support as discussed at the meeting and ensures that the employee is appropriately supported to help them achieve and maintain the required standard. The employee is required to fully co-operate during this period, to achieve and then maintain the improvement outlined.

The normal improvement period would be three months although in some circumstances this may be extended to a maximum of six months. During the whole of the monitoring period regular supervision is provided. If the improvement note and support does not achieve the required effect, it can be escalated to the formal process.

7. FORMAL DISCIPLINARY PROCESS: STANDARD PROCESS

7.1 There will be situations where the facts of the case are very clear and not disputed by any party. In these circumstances it is beneficial for all concerned to have the matter dealt with and resolved as quickly as possible to reduce disruption and any unnecessary stress. To ensure that such issues are dealt with in a timely manner and negate the need to escalate unnecessarily, a manager involved at the informal stage would also be able to deal with it formally. This would normally be applicable in cases of *minor misconduct or errors* and would not apply to any conduct considered to be serious or gross misconduct. The principles of the ACAS Code of Disciplinary Procedure should be followed.

- The facts of the situation must be established

- The employee is informed
- The employee has an opportunity to put their case and to be accompanied at any meeting
- A decision is taken on appropriate action and the employee has the right of appeal

7.2 In such cases, where the facts are not disputed, the manager, can hold a hearing, giving shorter notice than for a full hearing but with not less than 48 hours' notice. The manager will seek HR advice and guidance on the matter to ensure a consistent approach. The employee will be given written information about the facts that have been established and may be accompanied to the meeting. They will have an opportunity at the meeting to present their case and any mitigating circumstances.

7.3 The manager will make a decision on an appropriate action, having taken into account all the information provided, the guidance from HR and the approach or attitude of the employee. The employee will be advised of their right to appeal against the decision and outcome. If a manager considers more information is required in order for them to make a fair and reasonable decision, they *may* request an investigation is undertaken. If this happens the process will then follow the policy as outlined in Section 8

8. WHEN THE STANDARD PROCESS CANNOT BE APPLIED

8.1 The intention should always be to resolve an issue appropriately at the earliest possible opportunity. The Trust operates an escalation of procedures which can be invoked according to the nature and seriousness of the allegation, consisting of the formal stages outlined below.

8.2 Depending on the seriousness of the offence, it is possible to skip stages, being consistent with the three levels specified in the introduction. Dependent on the individual circumstances of a case and the severity of the misconduct, it may be appropriate to move directly to a final written warning. This might occur where the employee's actions have or are liable to have a serious or harmful impact on the organisation. In cases of gross misconduct which would have serious consequences, dismissal could be considered for a first offence.

8.3 The way in which managers deal with allegations of misconduct may depend on:

- The seriousness of the allegation; whether it is a minor offence or something that amounts to serious or gross misconduct *(see Appendix 2)*.
- Whether the alleged misconduct is an isolated incident or has been the subject of previous or ongoing concern which has previously been addressed and/or documented.

9. LEVELS OF WARNING/OUTCOMES

9.1 **First written warning** – if the conduct is sufficiently serious, repeated minor offences or if there has been no improvement following informal discussion, it may be appropriate to issue a first written warning, which will normally remain active for 6 months. The warning will stipulate the change in behaviour required, the period for which the warning will remain active and the likely consequences of further misconduct in that active period. The progress of the employee will be regularly monitored through regular supervision. Where conduct has improved but there remain some areas where further improvement is required, the Trust may decide to extend the active period as an alternative to taking further formal action. This would only be actioned after a

discussion with the member of staff and they are clear about what further improvement is required. An extension would be in line with the normal improvement period of three months which may, in specific circumstances, be extended to a maximum of six months. After that, there should be no further extension of the original warning and the next appropriate step should be considered in line with this policy. After the active period of a warning, it will generally be disregarded.

9.2 **Final written warning** – if the conduct is sufficiently serious or if there has been no improvement following the issuing of a first written warning which is still active, it may be appropriate to issue a final written warning. Final written warnings will normally remain active for a period of 12 months. The warning will stipulate the change in behaviour required, the period for which the warning will remain active and the likely consequences of further misconduct in that active period. In very exceptional cases, due to the seriousness of the misconduct, this period may be extended in line with the process outlined in the previous paragraph. After the active period of a warning, it will generally be disregarded.

9.3 **Dismissal** - if the conduct is sufficiently serious or if there has been no improvement following the issuing of a final written warning which is still active, it may be appropriate to dismiss the employee. Dismissal will also be considered when the matter is so serious it amounts to gross misconduct *(see Appendix 2)* and warrants dismissal for a first offence. In cases of gross misconduct, the Trust reserves the right to summarily dismiss staff. Only those managers with the authority to dismiss may take this action.

Dismissal with notice will be appropriate for situations where previous warnings have failed to elicit acceptable standards of conduct from the employee, or in extremely serious circumstances.

Dismissal without notice will only be used in cases of gross misconduct

9.4 Alternative Action to Dismissal

During this final hearing stage consideration will be given to action short of dismissal. This may include:

- Consideration of redeployment
- Downgrading to a post of lesser responsibility
- Training or Coaching, etc.

This list is not exhaustive and alternative action should not be considered an automatic right by the employee and will be subject to the needs of the service and consideration of all the facts.

Where an alternative to dismissal is offered no protection to remuneration or benefits will apply and the employee will be employed on the terms and conditions pertaining to the post, following statutory notice as outlined within the employee's contract of employment.

10. SUSPENSION FROM DUTY

Guidance on suspension and the Risk Assessment template can be found in the Best Practice Guide to Investigations and Suspension

11. THE RIGHT TO BE ACCOMPANIED

11.1 At all stages of the formal procedure, employees are entitled to be accompanied by a

Staff Side representative or work colleague not acting in a legal capacity. Employees are responsible for arranging their representation.

11.2 Managers will advise employees of this when an allegation of misconduct is made against them, but it is the employee's responsibility to arrange for their companion to be present at any stage of the formal procedure and to notify the investigating manager of their identity and role at least 3 days before the meeting or hearing.

11.3 If disciplinary action beyond informal guidance is considered against an accredited staff representative, the manager or HR representative will involve the appropriate full-time officer of the representative's union, prior to any action being taken.

11.4 An accredited representative may choose to be represented by a full-time trade union officer, at all formal stages in this procedure.

12. RESPONSIBILITIES

Please refer to responsibilities outlined in Appendix 1

13. APPEALS

13.1 Employees have one right of appeal at each formal stage of this policy.

13.2 **Appeals against formal reviews**

Employees wishing to appeal against a formal review must give notice of appeal to the line manager of the manager issuing the review.

Appeals must be lodged, in writing, to the named HR Representative within 14 calendar days of date of the hearing.

The notice of appeal must clearly outline the grounds for appeal and include any additional supporting information the employee wishes to be considered. Those reasons should fall within one or more of the following categories:

- Inadequate investigation and insufficient substantiation of issues.
- Procedural irregularity and unfairness.
- Unreasonable action.

NB: this list may not be exhaustive

13.3 **Appeals against redeployment/dismissal**

Employees appealing against a decision to dismiss have a single right of appeal to the Executive Director for that directorate or if the manager conducting the disciplinary hearing was an Executive Director of the Trust another Executive Director not previously involved in any previous stage of the case.

Employees appealing against a decision to redeploy have a single right of appeal to the Director for that directorate or, if the manager conducting the disciplinary hearing was the Director of the directorate, another Director of a similar level not previously involved in any previous stage of the case. If the appeal against redeployment is upheld, the alternative and potential outcome of the appeal could be dismissal

Appeals must be lodged, in writing to the Assistant Director of HR (Operations) within 14 days of the date of the hearing.

The notice of appeal must clearly outline the grounds for appeal and include any

additional supporting information the employee wishes to be considered.

14. PROFESSIONAL ISSUES/ADVICE

14.1 In cases involving professional issues, the appropriate accountable professional manager or adviser must be involved in all formal stages of this policy.

Where there is no suitable professional manager within the structure, the Manager dealing with the case has discretion to appoint an external professional adviser.

15. REFERRAL TO STATUTORY, REGULATORY OR PROFESSIONAL BODIES.

15.1 There may be instances where the manager and professional adviser decide that it is appropriate to notify a relevant statutory professional body that disciplinary action is being taken against an employee. When dealing with cases that have the potential to fall into this area, whether informal or formal action is being considered, advice must be sought from the HR Department

15.2 In the majority of cases, such referral will only apply in cases of serious/gross incompetence and/or where the individual is being dismissed. Should this be necessary, the HR Adviser to the panel will ensure that the relevant professional body is consulted and/or notified as appropriate and in accordance with the professional bodies' code of ethics/conduct. Staff must be informed that their professional body has been notified and of any subsequent action.

15.3 **Independent Safeguarding Authority (ISA)**

Under the terms of the Safeguarding Vulnerable Groups Act (2006), employers have a legal duty to make a referral to the ISA where they have dismissed or removed a member of staff or volunteer (or where they would have been removed or dismissed had they not left of their own accord) from working in regulated activity because they have harmed, or posed a risk of harm, to a child or a vulnerable adult. The Trust will, therefore, make referrals to the ISA in such cases.

15.4 **The Care Act 2014**

The Care Act 2014 places a duty on everyone to safeguard adults at risk of harm and neglect. Safeguarding adults comes under the Care Act 2014. There is a duty for all SCAS employees to refer concerns against persons at risk and alleged perpetrators. Please refer to SCAS Safeguarding Adult Policy and consult with your Manager in the first instance.

15.5 **Children Act 1989 & 2004**

The Department for Children, Schools and Families' Working together to safeguard children (2018) sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004. Please refer to SCAS Safeguarding Children Policy and consult with your Manager in the first instance.

15.6 **Sexual Offences Act 2003**

In the past there have been difficulties in bringing prosecutions against individuals who committed sexual offences against people with mental disorders. The Sexual Offences Act (SOA) 2003 modernised the law by prohibiting any sexual activity between a care worker and a person with a mental disorder while the relationship of care continues.

A 'relationship of care' exists where one person has a mental disorder and another person provides care. It applies to people working both on a paid and an unpaid basis and includes:

- doctors
- nurses
- care workers in homes
- workers providing services in clinics or hospitals
- volunteers.

The offences in the Act relating to care workers apply whether or not the victim appears to consent, and whether or not they have the legal capacity to consent.

This does not prevent care workers from providing intimate personal care so long as the behaviour is not intended to be sexual. The Act is not intended to interfere with the right of people with a mental disorder who have the capacity to consent to engage in sexual activity with anyone who is not in a caring relationship with them.

The SOA also attempts to make the prosecution of rape easier by clarifying the meaning of consent. Section 74 of the Act provides that someone consents to a sexual act if, and only if, he or she agrees by choice and has the freedom and capacity to make that choice.

SCAS employees should consult with their Manager, Safeguarding Children and Adult in the first instance.

15.7 Safeguarding Vulnerable Groups Act 2006 and the Protection of Freedoms Bill

This Safeguarding Vulnerable Groups Act (SVGA) 2006 was passed to help avoid harm, or risk of harm, by preventing people who are deemed unsuitable to work with children and vulnerable adults from gaining access to them through their work.

The Independent Safeguarding Authority was established as a result of this Act. On 1 December 2012 the Criminal Records Bureau and Independent Safeguarding Authority merged to become the Disclosure and Barring Service (DBS).

The legal duty to refer to DBS, applies to regulated activity providers even if a referral has been made to another body (such as a local authority safeguarding team or professional regulator), regardless of whether that body has also made a barring referral to DBS. Regulated activity is work that a barred person must not do.

15.8 Ill treatment or wilful neglect

It is an offence under the Criminal Justice and Courts Act 2015 for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual.

Under S44 of the Mental Capacity Act, ill-treatment and wilful neglect is a criminal offence for anyone, including those with powers of attorney and court appointed deputies, who has care of a person who lacks capacity

Ill treatment and wilful neglect are different. Ill treatment must be deliberate, is an

offence irrespective of whether it causes harm, and involves an appreciation by the perpetrator that they were inexcusably ill-treating the person. Ill treatment includes acts such as hitting, administering sedatives to keep people quiet, pulling hair, rough treatment, verbal abuse or humiliation.

Wilful neglect is a failure to act rather than a deliberate act to commit harm. Managers with responsibility for ensuring good care can be held accountable but currently there is no offence of corporate neglect.

16. OFF-DUTY MISCONDUCT AND CRIMINAL CONVICTIONS

16.1 The Trust always expects good conduct from its staff. Therefore, where conduct outside of the workplace has a direct or indirect effect on the work or reputation of the Trust or affects the suitability of that individual or their acceptability to the Trust or other employees, the matter may be subject to this procedure.

16.2 All employees are bound by the policies of the Trust. Off duty misconduct (including criminal offences) will not normally be treated as an automatic reason for dismissal and neither will employees be dismissed solely because a charge against them is pending or because they are absent through having been remanded in custody. Where staff are charged with a criminal offence, the Trust will carry out an independent investigation in accordance with Appendix 1 of this policy to determine whether the matter needs to be considered at a disciplinary hearing, based on the balance of risk to the organisation.

16.3 All employees are required to advise their manager of any criminal convictions or charges made against them whilst they are employed by the Trust.

16.4 **Alcohol and Drugs Misuse**

Where an individual's conduct/performance is affected by an alcohol or drug problem support will be provided in accordance with the Trust's Alcohol and Drugs Policy.

16.5 **Counter Fraud, Bribery and Corruption**

If the concern is suspected to be fraud, bribery or corruption the Line Manager/HR must report this to the Local Counter Fraud Specialist (LCFS), who will liaise with the Director of Finance and Human Resources to reach an agreement on the approach.

Fraud and/or Bribery is a criminal offence and therefore not acceptable at SCAS and due to this is likely to be considered as gross misconduct. The Trusts Counter Fraud Policy and Anti-Bribery Policy defines the basic offences and clarifies how the Trust will progress suspicions of fraud/bribery.

A counter fraud-led investigation will usually be undertaken without the knowledge of the suspected employee. This will be continually reviewed by the LCFS and SCAS HR until such time as considered appropriate to inform the suspected employee.

16.6 **Public Interest Disclosure Act 1998**

An important part of providing care is ensuring a working environment that encourages people to challenge practices in their own workplace. The law offers some protection from victimisation to people who blow the whistle under the Public Interest Disclosure Act (PIDA) 1998. The parameters of 'protected disclosure' are set out in the Employment Rights Act (ERA) 1996. The person making the disclosure should not commit an offence in doing so (e.g. breach the Official Secrets Act 1989) and must reasonably believe one or more of the following:

- that a criminal offence has been committed, is being committed or is likely to be committed
- that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he or she is subject
- that a miscarriage of justice has occurred, is occurring or is likely to occur
- that the health or safety of any individual has been, is being or is likely to be endangered
- that the environment has been, is being or is likely to be damaged
- that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed. (ERA1996).

17. TIMESCALES AND EXCEPTIONAL CIRCUMSTANCES

17.1 It is acknowledged that there may, on occasion, be *exceptional* circumstances where it is not possible to comply with the timescales detailed in the Best Practice guide. In such cases, either the employee or the manager must notify the HR Department as soon as possible in order that the circumstances can be considered sympathetically, and an extension may be considered. It is the responsibility of all involved in the case to make every reasonable effort to ensure the matter is dealt with in a timely manner to avoid unnecessary stress.

18. RECORD-KEEPING & MONITORING

18.1 A written record of all decisions taken in accordance with this policy will be retained on the employee's personal file.

18.2 If in the exceptional circumstances, a note taker is not available, the proceedings (investigation interviews, meetings and hearings) may be recorded provided that all participants agree, to ensure that a full and accurate transcript of the hearing can be produced. A copy of the recording will be available as required but will only be transcribed in the event of an appeal process being instigated. The recording of any meeting can only be done by mutual agreement. Any covert recording done of a meeting or hearing would be considered serious misconduct and will be dealt with under this policy.

18.3 All documentation will be treated confidentially and in accordance to the General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) and SCAS' Lifecycle Policy. There must be a full written record consisting of letters, emails, transcribed phone calls or (signed and dated) meeting notes. The contents and outcomes of informal meetings should also be confirmed in writing and retained. NB: Notes made relating to any disciplinary or conduct issues must be stored securely and placed in the HR personal file which is retained in a secure place.

18.4 Employees may access any documentation held on them in accordance with the General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) and notify any inaccuracies to those responsible.

18.5 **Deferral and Extension of Written Warnings**

a. In normal circumstances, it is not appropriate to extend the period of time that a disciplinary warning remains on an employee's personal file. However, if the

manager has been unable to review the individual's progress due to staff absence, consideration should be given to extending the warning. They will then hold a formal meeting with the employee to discuss the possibility of extending the warning.

b. The formal meeting must take place before the expiry of the original warning and the employee must be given at least 7 calendar days' notice in writing of the meeting and its purpose. The employee will have the right to be accompanied at the meeting by their trade union representative or a colleague and the manager convening the hearing must be accompanied by a member of the HR department.

c. Warnings will be deferred and/or extended in the event of the member of staff being absent from work in excess of one calendar month. The length of such extensions should mirror the absence (eg, in the event a member of staff is absent for six weeks, the warning should only be extended by six weeks).

d. The warning may not be extended past the maximum time period of the original warning. If, at the end of the original warning period, there has been little or no improvement in the employee's conduct, then further disciplinary action should be considered by the manager.

e. All such decisions should be confirmed in writing outlining the reason for such and associated timescales.

18.6 **Removal of Disciplinary Records**

a. Any records relating to disciplinary penalties in a personal file are not current after the expiry of the warning.

b. "Spent" warnings cannot be taken into consideration in any subsequent internal review of the individual's conduct or performance, except in exceptional circumstances, such as where there have been repeated warnings issued for disciplinary offences of a similar nature.

c. If an Appeal results in a disciplinary penalty being withdrawn then all evidence, reports, correspondence and information will be removed from the individual's file.

19. OCCUPATIONAL HEALTH

19.1 The Trust reserves the right to refer employees to Occupational Health (OH) at any point of the process. The purpose is for assessment and medical advice and to gain an understanding of any health issues affecting the employee's fitness to undertake their contractual duties and/or suitable alternative duties, or to attend a disciplinary meeting or hearing. It is also to ensure that the Trust is offering the employee all appropriate support in this respect.

19.2 Managers must discuss the reason for referral with the employee prior to the referral being made. As with all OH referrals, the employee will automatically be sent a copy of the manager's referral letter prior to their OH appointment. Employees do not need to be absent due to sickness/ill health in order to be referred to OH.

20. POLICY REVIEW

The effectiveness of this policy will be monitored regularly by HR who will provide data on the use of the policy as and when required. Annual report will be provided to the Trust board at the end of each financial year. The results of the annual staff survey will also provide a valuable indicator of any problems.

In advance of the review date, the HR team will review and produce recommendations which will be shared via the recognised policy approval process (HR Policy Review Group) in time for the policy review date. An early review can be triggered by the Trust Board, HR or joint staff side if they have serious concerns about the policy or its implementation.

21. RELATED POLICIES & GUIDANCE

21.1 Please read this policy in conjunction with the following:

Capability Policy

Best Practice Guide to Investigations and Suspension

Best Practice Guide to Hearings and Appeals

Dignity at Work Policy

Equal Opportunities Policy

Grievance Policy

Freedom to Speak Up

NHS Managers' Code of Conduct
http://www.nhsemployers.org/SiteCollectionDocuments/Code_of_conduct_for_NHS_managers_2002.pdf

Internet Policy (especially for information relating to misuse of Social Networking sites)

22. FURTHER INFORMATION

The following sources of information can give perspective and context to the policy and procedure:

ACAS code of practice: http://www.acas.org.uk/index.aspx?articleid=2174

Government guidelines: http://www.direct.gov.uk/en/Employment/ResolvingWorkplaceDisputes/Disciplinaryprocedures/index.htm

The union view: www.unison.org.uk; www.unitetheunion.org; www.rcn.org.uk

A Just Culture Guide – (https://improvement.nhs.uk)

Being Fair – NHS Resolution
Discipline & Conduct Policy Toolkit

APPENDIX 1: RESPONSIBILITIES

1. **Manager is responsible for:**

- Leading by example, exhibiting behaviour which meets the Trusts standards at all times, and which are in line with the Trust's values.
- Investigating complaints or allegations concerning members of staff promptly and taking appropriate action.
- Providing employees with sufficient communication, information and education to enable them to effectively carry out their duties
- Making every effort to resolve issues on an informal basis where appropriate
- Supervising and guiding staff on a day-to-day basis, instilling a culture of encouragement and support and identifying areas and opportunities for improvement at an early stage and setting realistic and measurable targets for standards of conduct and work performance, clearly explaining those standards to staff
- Meeting and monitoring staff regularly to ensure that once acceptable standards have been achieved these are maintained, taking appropriate action if standards begin to deteriorate
- Putting in place robust appraisal and supervision arrangements and identifying any training needs to enable staff to achieve the standards expected of them throughout their employment
- Seeking HR advice as soon as possible when a problem occurs
- Seeking advice & guidance from HR when dealing with formal aspects of this policy and ensuring that an HR representative is present at formal meetings and/or hearings
- Making employees aware of their rights and entitlement under the policy immediately an allegation of misconduct is made
- Completing and providing all relevant and/or appropriate documentation in accordance with these procedures
- Adhering to the NHS Managers' Code of Conduct.

2. **Human Resources (HR) are responsible for:**

- Providing advice and facilitating the appropriate use of the policy
- Providing coaching and practical advice to managers when developing or changing the working environment, job functions and/or performance standards thus ensuring that managers have the necessary skills and knowledge to deal with disciplinary matters
- Providing professional and expert advice on the application of this policy and to ensure it is consistently applied
- Attending formal stages of the disciplinary procedure, including disciplinary and appeal hearings
- Monitor the effectiveness of measures taken to address disciplinary issues within

the Trust by collating and analysing Trust-wide absence levels, employee relations issues and ensuring that Equality and Diversity KPIs are monitored.

3. **Employee is responsible for:**

- Ensuring that they are aware of, comply with and maintain expected standards of conduct in accordance with Trust values, policies, procedures, working practices and relevant professional codes of conduct and the behaviour that constitutes a disciplinary offence, including gross misconduct, under this policy
- Notifying their manager of any issues which could make it difficult for them to comply with standards of conduct expected of them
- Participating in informal and formal reviews of their individual performance in accordance with the appropriate policy and procedure
- To co-operate with any investigation that is undertaken in order to establish facts and information around an incident or situation and any subsequent hearing.
- Complying with education, training and coaching provided to help them maintain their skills, and knowledge
- Ensuring confidentially is maintained at all times when involved, either directly or indirectly, with any element of this policy
- Organising a companion if they choose to be accompanied at a formal meeting or hearing. The procedures (including investigation) outlined within this policy cannot be unduly delayed if the companion has not been notified in good time.

4. **Staff Side and Trade Union Representatives are responsible for:**

- Ensuring that employees are appropriately advised and supported throughout the disciplinary process
- Facilitating and enabling due process in accordance with this procedure
- Liaising with all relevant parties
- Endeavouring to maximise high standards and minimise poor performance by supporting the Trust in the provision of information, education, training and coaching to enable staff to effectively carry out their duties. Participating in communication campaigns to ensure that staff are aware of the standards of conduct and work performance expected
- Supporting the organisation in the continual review and development of working practice, performance standards, policy and procedure, and
- Attending accredited union education, training and coaching provided to help them maintain their skills, and knowledge within the area of discipline and conduct.

5. **Responsible Manager is responsible for:**

- The Responsible Manager will usually be the senior line manager or Head of Department accountable for the employee whose conduct has come into question. They will be responsible for considering and reviewing the alleged misconduct and, in the event of an investigation being required, the responsible manager is responsible for appointing the investigating officer and ensuring that they:

- Are appropriate in the circumstances, have the relevant experience and there is no conflict of interest
- Are given appropriate resources (including time) to complete the investigation in a timely manner
- Adhere to the timescales set and if extensions are required the affected employee and HR department are advised accordingly
- Setting the terms of reference for the investigation
- Ensuring that the employee's companion is afforded appropriate facilities and time as detailed in the Trust's Trade Union Recognition Agreement
- On completion of the process the Responsible Manager must ensure that the organisational learning is appropriately disseminated and/or communicated through the appropriate process

6. **Investigating Officer is responsible for:**

- Ensuring a comprehensive and robust investigation is undertaken in full accordance with this policy and the best practice guide to investigations, *ACAS* guidelines and current employment law.
- Investigations are commenced and completed without undue delay, following the allocation of terms of reference.
- The investigation adheres to the timescales set and if extensions are required the affected employee and HR department are advised in writing (email is acceptable);
- The allegation is disclosed to the employee(s) under investigation and that a full explanation of the investigation procedure is given.
- Ensuring the employee under investigation and their representative, are kept informed of the process of investigation and will be given a contact for information.
- All other relevant policies and procedures are adhered to, in particular the Equal Opportunities and Single Equality Scheme.

APPENDIX 2: **DISCIPLINARY PROCEDURE**

1. Informal Discussion

1.1 Many conduct / performance matters can and should be dealt with through informal discussion and this will ordinarily be the first step in tackling an employee's poor conduct/performance. The formal disciplinary procedures should only be used where such discussion has not produced a change in behaviour or where a clear and/or serious breach of discipline occurs.

1.2 Staff must be made aware that a failure to respond to informal discussions could lead to formal disciplinary action being taken.

1.3 Informal action will be inappropriate in circumstances where there is a potential case of serious/gross misconduct. Such issues should be dealt with at a first or final formal hearing in accordance with the formal procedure.

1.4 The manager will establish the facts to ascertain whether an informal discussion, a shortened formal meeting (see section 9 of the policy) is appropriate or whether a more detailed investigation needs to be undertaken.

1.5 Careful consideration must be given to the individual's role, remit and duties; in particular, the service provision responsibilities and/or any staff managed or supervised by the individual. The key considerations must be:

- the significance of the matter in question
- whether or not the individual was acting in accordance with Trust strategy, policy or Management guidance
- the extent of the individual's direct actions
- the detrimental effect / scope of the actions
- the reasonableness of the individual's actions

1.6 The manager must record the fact that the meeting has taken place and confirm in writing the key points discussed, including the objectives set, support put in place, timescales for improvement and method for review and monitoring. Furthermore, employees must be reminded of the consequences of continued poor conduct and that this may lead to a formal action being taken in accordance with section 6 of the policy.

1.7 Consideration must be given if an **improvement note** would give greater clarity and structure to achieve improvement

1.8 The manager must confirm the outcome of the meeting and associated action plan within 7 calendar days of the meeting.

1.9 The objectives/action plan will be continuously reviewed by the manager during the review period. Where an employee's conduct/performance improves to the required standards the employee must be notified in writing, clarifying that the employee needs to maintain satisfactory levels of performance and failure to sustain improvements in a period of up to 6 months may result in further/formal action being taken. A copy of this letter will be retained on the individual's personal file.

2. Formal stages

Consideration must be given as to whether it is appropriate to use the standard process as outlined in section 7.

3. First Formal Hearing

3.1 Where an informal approach has not achieved an acceptable or sustained improvement in conduct/performance, an informal discussion is not appropriate in the circumstances or the standard process is not applicable, an appropriate manager, in consultation with an HR Adviser, should consider convening a formal review meeting.

3.2 Following a full investigation, the manager should arrange to meet with the employee, giving them at least 10 calendar days' written notice of the meeting. The letter must outline the purpose of the meeting, the employee's right to representation along with the fact that the outcome of the meeting might result in a formal warning letter being issued.

3.3 The letter must include a copy of all documentary evidence, records and reports relevant to the review. Depending on the nature of the issue it may be appropriate to submit such documentation in the format of a 'case file'.

3.4 The Manager will be accompanied and advised by an HR Representative at this meeting and/or a professional adviser if appropriate

3.5 During the review meeting the employee will be given the opportunity to respond to the perceived poor conduct/performance and put forward any mitigating factors and/or any new problems which may be contributing to the poor conduct/performance.

3.6 The outcome of the review meeting will be confirmed in writing to the employee within 7 calendar days of the meeting. This letter must include, as a minimum, the level of formal warning given, details of the actions agreed, timescales for improvement, methods for review and monitoring, and the employee's right of appeal. Furthermore employees must be reminded of the consequences of continued poor conduct/performance and that this may lead to a further review and/or redeployment.

4. Final/Formal Hearing

4.1 If, after informal and formal stages have been exhausted and the member of staff continues to fail to reach the required standards in the specified period **OR** informal action/formal review is inappropriate, eg in the event of serious/gross misconduct

4.2 The manager responsible for the early stages in this policy ***or*** the investigating officer must document their findings in the form of a case file identifying pertinent issues and providing supporting factual evidence.

4.3 Dependent upon the circumstances, the case may also include written statements of complaint or concern, verbal statements taken at interview, work records, professional advice or opinion and may refer to information contained on the individual's personal file.

4.4 The manager responsible for the former stages in the policy will attend the hearing to present their report and their account of the performance review process and/or subsequent investigation.

4.5 The formal hearing will take place in accordance with Best Practice Guide to Formal Hearings & Appeals.

5. Serious/Gross Misconduct/Dismissal

5.1 An employee will not normally be dismissed because of a failure to perform to the required standard unless review and an opportunity to improve have been given.

5.2 However, where an employee commits a single act of serious and/or gross misconduct a formal review may not be appropriate and dismissal action may be taken in such circumstances in accordance with section 8 of this policy. In such cases, a full investigation will be required in accordance with this policy.

5.3 During the investigation a period of suspension or restriction of duties may be necessary, in line with the procedures outlined in the Best Practice Guide for Investigations and Suspension

APPENDIX 3: THE INVESTIGATION

The Best Practice Guide to Investigations and Suspensions provides more detail of undertaking an investigation and should be read first. Where accepted standards of conduct or behaviour are alleged to have been seriously breached, a manager with appropriate authority (the Responsible Manager) will decide whether an investigation of the facts and circumstances surrounding the situation is required, if so this Manager will:

1. Assign another manager to be the Investigating Officer to undertake a full and impartial investigation. Employees who have been requested to provide statements as part of an investigation will have the right to let their trade union representative view their statement prior to its submission, although this should not unduly delay the investigation.

2. Upon receipt of the investigation report, in consultation with the HR Representative, decide whether there is a case to answer and whether a disciplinary hearing should go ahead on the evidence made available or whether informal discussion may be more appropriate.

3. It is not the remit of the investigating officer to either determine the level of disciplinary action to be taken if any or issue any disciplinary warnings (informal or formal).

4. It is important to recognise the impact on staff and service provision when an issue is being managed under this policy. Delays should be kept to a minimum and all staff should prioritise investigations. In normal circumstances, investigations should be completed and, if required, a disciplinary hearing held, within 6 weeks. Only in exceptional circumstances this timescale may need to be extended. Where an investigation and disciplinary hearing is not possible within this period, the employee must be advised in writing by the Responsible Manager or investigating officer, explaining the reasons why.

5. It may be a conclusion of the investigating officer that the issue is one of capability rather than conduct; if this circumstance arises the investigating officer must discuss this with the Appointing Manager as soon as possible to determine the most appropriate course of action.

6. Where an investigation has concluded that a disciplinary hearing is not appropriate or necessary, a meeting should be held with the employee to relay this as soon as possible. The outcome of this meeting must be confirmed to the employee within 7 working days of the meeting.

7. Where an investigation is not necessary, e.g., in the event that the manager has compiled a case throughout earlier stages of this policy, or the employee has

confessed to the act of misconduct, the manager will arrange a disciplinary hearing in accordance with standard process outlined in Section 7.

8. All papers and reports relating to any investigation must be returned to the HR Department at the conclusion of the proceedings.

APPENDIX 4: THE FORMAL DISCIPLINARY HEARING

Full details of how a formal disciplinary hearing should be organised and managed can be found in the Best Practice Guide to Formal Hearings and Appeals together with details of the process and timescales for confirming the outcome of a hearing.

APPENDIX 5: OFFENCES WHICH CONSTITUTE GROSS MISCONDUCT

Gross Misconduct is behaviour considered to be very serious because of its nature and consequences and that it fundamentally breaches and destroys the contractual relationship between employer and employee. It makes any further working relationship and mutual trust impossible and justifies the Trust in no longer continuing with employment of that individual.

The following list summarises the types of offences that may constitute gross misconduct. Other conduct not included may be so self-evidently unacceptable as to justify dismissal without notice and without prior disciplinary warnings.

- Violence or other exceptionally offensive behaviour
- Any act or omission with intent to deprive the Trust of money or goods belonging to the Trust, due to it or in its safekeeping.
- Wilful damage to Trust's property or equipment.
- Dishonesty, eg, fraud including falsification of timesheets, qualifications, expense claims, misappropriation or theft of articles or money belonging to patients, other employees, visitors, contractors, voluntary organisations or the Trust.
- Any deliberate or reckless act or omission constituting a serious risk to the health and safety of any person including smoking in areas of fire or other hazard, vehicles or premises in accordance with the Trust's smoking policy.
- Ongoing refusal to carry out a reasonable management instruction or continued wilful contravention of Trust policies and/or procedures.
- Causing harm or wilful neglect of patients.
- Breaches of confidentiality, unauthorised disclosure of information, this may include social media
- Conduct likely to give offence to patients, other employees, visitors or the general public.
- Physical assaults on patients, other employees, visitors or members of the public.
- Sexual or racial harassment (as defined in the Trust's Dignity at Work Policy) of other employees, visitors or members of the public.
- Being in attendance at work whilst under the influence of or affected by abuse of substances, e.g., alcohol or drugs, other than those medically prescribed.
- Criminal conduct outside work which is relevant to the employee's job and which makes them unsuitable for the duties and responsibilities of their post.
- Undertaking paid work for a different employer without prior permission that then affects an employee's ability to undertake the full range of their work responsibilities.
- Failure to declare any 'conflict of interest' which could be seen to result in actual or potential or material gain.

- Unauthorised entry to the Trust's Information Technology systems/ unauthorised use of software or files.
- Knowingly making false or malicious allegations against other Trust employees.
- Unauthorised absence from work for which no acceptable reason has been given.

APPENDIX 6: LEVELS OF DISCIPLINARY AUTHORITY

Job titles and positions are subject to change in line with the development of the organisation. Levels of authority may be different and will be decided within Directorates. Examples of the levels of authority to take appropriate management action are contained in the Best Practice Guide to Formal Hearings and Appeals.

APPENDIX 7: MANAGERS' GUIDE TO MANAGING DISCIPLINE

1. Encourage improvement and achievement of performance/conduct standards

The main purpose of operating a disciplinary procedure is to encourage improvement in an employee whose performance/conduct is below acceptable standards, and it should be read in conjunction with the Trust's Best Practice Guides.

It aims to:

- promote the expected standards of performance and conduct
- ensure that any concerns about an employee's conduct are addressed effectively through a clear, fair and supportive procedure
- provide a clear procedure for the equitable and consistent treatment of staff where breaches of discipline are alleged.

2. General Provisions

2.1 Act promptly

2.1.1 Where problems are identified and dealt with at an early stage, there is a chance that they can be resolved quickly. Delay, however, can make things worse as the employee may not realise that they are performing below standard until they are informed. Managers must arrange to speak to the employee as soon as possible after the alleged disciplinary breach – it may then be possible to deal with the matter informally and avoid having to invoke the formal disciplinary process.

2.1.2 An initial 'coffee cup' conversation can help address problematic behaviour. This could be done as a welfare check to ensure there are no underlying causes of the problematic behaviour. In many cases, the right word at the right time and in the right way may be all that is needed and will often be a more satisfactory way of dealing with a breach of rules or unsatisfactory performance, than a formal meeting. To maintain confidentiality and avoid unnecessary embarrassment, such a conversation should be held in a neutral, private location. Additional training, coaching and advice may be needed, and the employee should also be made aware that, depending on the circumstances, it could lead to a formal discipline and conduct processes starting if there is no improvement or if any improvement fails to be consistent

2.2 Gather the facts

By acting promptly, the relevant supervisor or manager can clarify the problem and gather information while it is current; including anything the employee has to say.

Where necessary, statements must be obtained from all witnesses at the earliest opportunity. Records must be kept regarding the conversation with the member/s of staff involved – copies may need to be given to the individual if the matter progresses further and must be kept in the form of a 'case file'. Relevant personal details such as previous performance, length of service and any current warnings will need to be obtained before any formal meeting, as well as any appropriate records (such as training records or proof of having read policies) and documents.

2.3 Consistency

The attitude and conduct of employees may be seriously affected if management fails to apply the same rules and considerations to each case. Managers must work within the agreed policy framework and must seek advice from an HR Adviser on its practical application at the earliest possible opportunity. Managers must be aware that dealing with a case in a particular way may set a precedent.

2.4 Consider each case on its merits

While consistency is important, it is also essential to take account of the circumstances and people involved. Individual details such as length of service, past disciplinary history and any current warnings will be relevant to such considerations. Where there are previous warnings, their relevance to the current allegation/breach must be duly considered in deciding whether it should be dealt with in a cumulative manner or as a separate issue. Any provocation or other mitigating circumstances must also be taken into account.

2.5 Equality

Any decision to investigate a case or discipline an employee must be reasonable in all circumstances and must not discriminate on grounds of age, race, sex, disability, sexual orientation or religion or belief.

3. Informal Action *(refer section 6 of the policy)*

How should an informal meeting be conducted?

- Meet with the employee in a confidential setting. This should be a two-way discussion, aimed at explaining the shortcomings in conduct and encouraging improvement. Criticism must be constructive, with the emphasis being on finding ways for the employee to improve and for the improvement to be sustained.

- During the meeting, objectives for the employee to achieve must be specific, measurable, achievable, realistic and timed (SMART)

- The employee's perspective must be listened to by the manager in response to the alleged breach. It may become evident during this meeting that there are no issues- if so, this must be made clear to the employee.

- Where performance improvement is required, the employee must understand and agree with the objectives that have been set, how their performance or conduct will be reviewed, and over what period. The employee must be advised that if there is no improvement against the objectives, the next stage will be the formal disciplinary procedure. The agreed action must be confirmed with the employee in writing, this is not an 'informal warning' and should not be referred to as such because this is a conflict of terms.

- Managers must be aware and ensure that any informal action does not turn into formal disciplinary action, as this may unintentionally deny the employee certain rights, such as the right to be accompanied or the premature involvement of HR at meetings. As a rule, neither the employee nor the manager should require to be accompanied at an informal meeting, which should be a one-to-one meeting between staff member and manager. There may, however, be occasions when the staff member will request that a work colleague is present and, where possible, this should be accommodated.

- Can the issue be resolved quite easily and relatively quickly or would a three-month improvement note be appropriate to provide clarity and structure to achieving the improvement or can the improvement be achieved?

- If, during the discussion, it becomes obvious that the matter may be more serious and it is not appropriate for it to be dealt with informally, the meeting must be adjourned. The employee must be advised that the matter will be subject to an investigation and will be managed following the formal disciplinary procedure – suspension may be appropriate in such circumstances).

If conduct continues to be unsatisfactory, the manager must initiate the formal procedure of the policy.

4. **Suspension with pay**

Where there appears to be serious misconduct, risk to property, service provision or other people (staff/patients), a period of suspension with pay or a restriction of duties must be considered while the case is being investigated. Any suspension must be on full pay and any period of suspension must be as short as possible. The employee must be advised of the exact reason for suspension, and that they will be called in for a disciplinary/investigation meeting as soon as possible. Suspension is a neutral act and does not imply that the individual is automatically guilty; it must not be used as a sanction before the disciplinary meeting and decision. Suspension must be reviewed every 14 days. More guidance on suspension can be found in the Best Practice Guide to Investigations and Suspensions

5. Formal Action

5.1 Follow the Discipline and Conduct Policy

Formal action is necessary where further breach es occur following informal action or if it is not appropriate for the matter to be dealt with informally.

The Discipline and Conduct policy must be followed in each case and the supervisor or manager must never act above the level of their authority as defined in Appendix 3.

5.2 The ‘Responsible Manager’ (usually the Senior Line Manager or Head of Department) must decide if an investigation is required in accordance with the Discipline and Conduct policy. This will be dependent on the following:

- The extent to which the allegation is proven, i.e., has the employee admitted the alleged disciplinary breach
- The documentary evidence available to support the allegation
- The requirement to take statements from/and or interview key witnesses

5.3 Having gathered all the facts, the ‘Responsible Manager’ must decide the following:

- Whether formal disciplinary action is necessary or
- If the matter can be managed through the informal process or
- Whether to use the standard disciplinary process – applicable if the facts are not disputed by either party and is acceptable to all parties – *refer section 7.1 of the policy*
- Whether to arrange a disciplinary meeting/hearing - this will be necessary when the matter is considered serious enough to require disciplinary action.

6. **Formal Disciplinary Hearing** (*refer section 7/8 of the policy)*

The employee must be informed in writing that a Meeting/Hearing has been convened. The letter must detail the following:

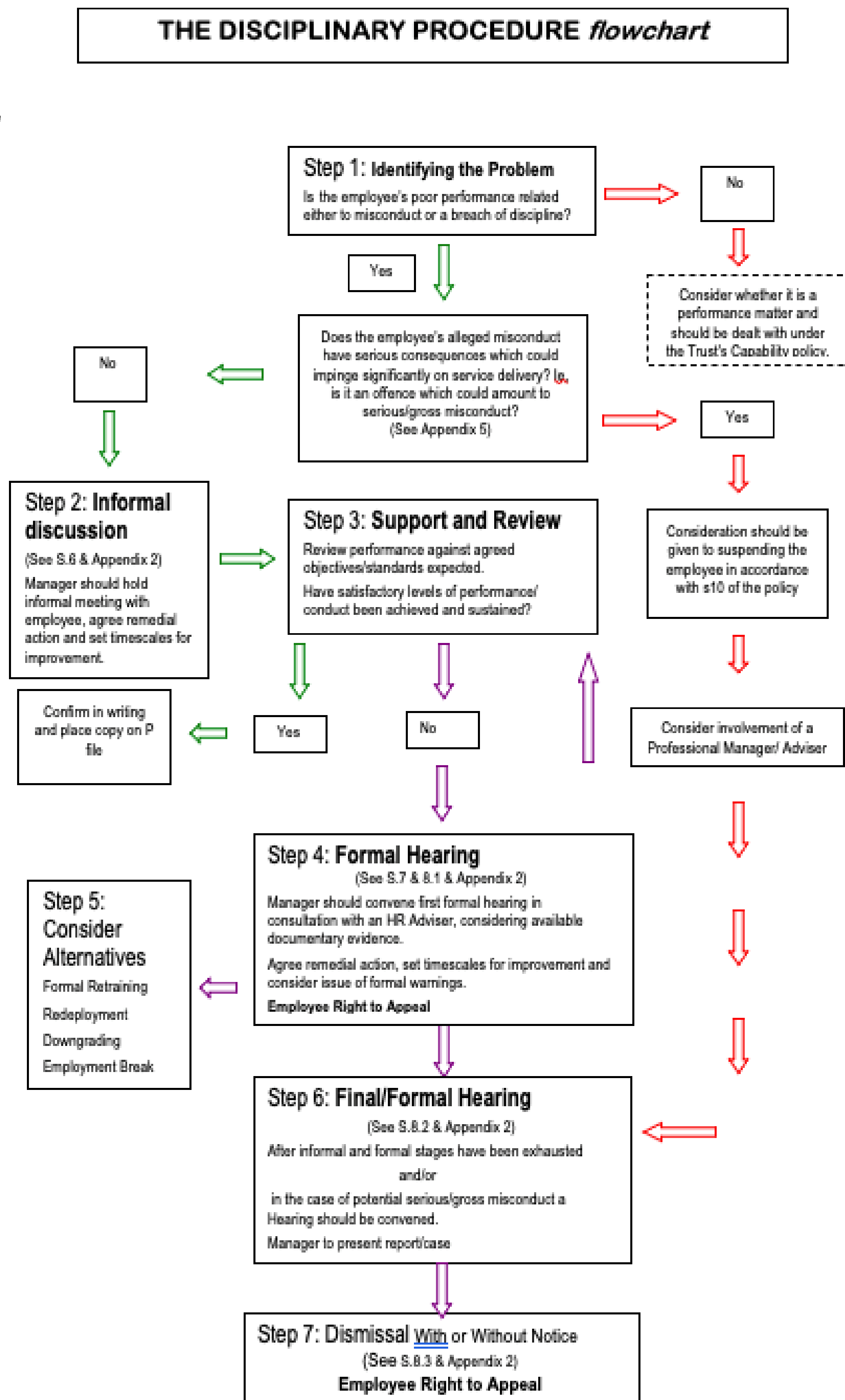
- Date, time and venue of the Panel, giving a minimum of ten calendar days’ notice
- Names of the panel members
- Right to be accompanied by a work colleague or trade union representative.

The letter of notification will also identify the allegations which are to be considered by the panel. Copies of the Management case file/supporting evidence must be provided 10 calendar days prior to the Hearing.

The Hearing will be held in accordance with the Trust’s Best Practice Guide to Hearings and Appeals.

If the employee is dismissed or incurs a disciplinary penalty short of dismissal - such as a formal warning - the statutory minimum procedures must have been followed and the panel decision confirmed to the employee in writing. The employee will have a right to appeal against the decision. If the procedures have not been followed and the employee makes a claim to an employment tribunal the dismissal will automatically be ruled unfair.

APPENDIX 8: FLOWCHART OF DISCIPLINARY PROCEDURES



APPENDIX 9: MAINTAINING HIGH PROFFESSIONAL STANDARDS

NHS
South Central Ambulance Service
NHS Foundation Trust

MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE MODERN NHS

DOCUMENT INFORMATION

Subtitle: Medical and Dental Annex to South Central Ambulance Service NHS Foundation Trust's Discipline and Conduct Policy

Version 1.0

Date of Issue: October 2020

South Central Ambulance Service NHS Foundation Trust
Unit 7 & 8, Talisman Business Centre, Talisman Road,
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1. INTRODUCTION

1.1. The Trust expects all Medical and Dental practitioners to work in line with its values, behaviours and the principles of “Delivering Compassionate Excellence” to ensure high quality patient outcomes but also the standards set out by professional bodies.

1.2. This procedure complies with the requirement to have procedures for handling concerns about the conduct, performance and health of Medical and Dental practitioners as described in ‘Maintaining High Professional Standards in the Modern NHS’.

1.3. The Trust will take all necessary steps to protect the safety of its patients.

2. SCOPE

2.1. The procedure applies to all Medical and Dental practitioners employed by the Trust.

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

3. AIM

3.1. This procedure 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

4. DEFINITIONS

4.1. 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 may fall:

4.2. **Conduct** - where the conduct or behaviour of a doctor or dentist:

4.2.1. 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

4.2.2. Is not consistent with the Trust’s values and behaviours

4.3. The Trust’s Discipline and Conduct Policy will apply if conduct is found to be impaired.

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

4.5. Opinion can be drawn from both internal sources, e.g. colleagues within the specialty, and external sources (particularly when there might be conflict of interest) such as clinicians from the same specialty working in other Trusts or Royal Colleges

4.6. **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 Maintaining High Professional Standards in the Modern NHS Policy V2.0 Page 8 of 59 to the NHS on resolving concerns fairly, share from learning for improvement and preserve resources for patient care.

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

4.8. **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.

4.9. **Glossary and abbreviations:**

4.9.1. Doctor – for ease, this term refers to all Medical and Dental practitioners employed by the Trust, including those in training and on honouree agreements.
4.9.2. GDC – General Dental Council
4.9.3. GPhC – General Pharmaceutical Council
4.9.4. GMC – General Medical Council
4.9.5. CCAS – Covid Clinical Assessment Service
4.9.6. NED – Non-Executive Director
4.9.7. RO – Responsible Officer
4.9.8. TOR - Terms of Reference – the remit for conducting an investigation.

5. RESPONSIBILITIES

5.1. **The Chief Executive** has overall responsibility for ensuring that concerns are managed in accordance with his procedure.

5.2. **The Director of HR & OD and the Medical Director** have delegated authority to manage the procedure. The Director of HR & OD will nominate a Non-Executive Director where required and inform the Case Manager.

5.3. **The Medical Director** is the Responsible Officer (RO) and has responsibility for:
5.3.1. The initial assessment of the seriousness of the concerns raised.
5.3.2. Acting as Case Manager or delegating that responsibility in appropriate
5.3.3. Referrals to the GMC/GDC.
5.3.4. Compliance with the conditions applied by the GMC/GDC.
5.3.5. Reviewing the types of concerns arising for potential systemic issues and if applicable addressing issues within the Trust which may have contributed to the concerns identified.

5.4. **Human Resources** are responsible for:

5.4.1. Supporting the application of this procedure at all stages.
5.4.2. Arranging for an accurate record of hearings.
5.4.3. Recording any actions on the Electronic Staff Record (ESR).

5.5. **Occupational Health** is responsible for:
5.5.1. Supporting the Doctor in relation to any health-related concerns and providing advice to the Trust.
5.5.2. Ensuring information is recorded accurately and in line with obligations of confidentiality

5.6. **The Case Manager** is responsible for:
5.6.1. Identifying the nature of the problem and assessing the seriousness of the concern with a view to deciding if a formal investigation is required or if an informal approach to resolving the concern is appropriate.
5.6.2. Seeking advice from the PPA.
5.6.3. Considering exclusion and/or restrictions in line with the terms of this procedure.
5.6.4. Producing Terms of Reference for any investigation and providing a copy of the Terms of Reference to the Doctor under investigation.
5.6.5. Maintaining appropriate oversight in relation to investigations ensuring quality of the content, timescales and safeguards in relation to confidentiality.
5.6.6. Ensure the Doctor is kept updated with regards to any delays in the investigation or changes to the Terms of Reference.
5.6.7. Deciding on further action following an investigation.
5.6.8. Keeping accurate and timely records of all discussions.
5.6.9. Informing and updating the Medical Director, NED and Director of HR and OD of steps taken under this procedure.

5.7. **The Case Investigator** is responsible for:
5.7.1. Ensuring that a fair, open and transparent investigation is completed to establish the facts relating to any concern.
5.7.2. Providing a written report on their findings within the given timescale
5.7.3. Updating the Case Manager about any delays in the investigation and providing reasons.
5.7.4. Ensuring safeguards are in place throughout the investigation to maintain confidentiality, as outlined in this procedure.
5.7.5. Where appropriate, attending any hearing.

5.8. **All Managers** are responsible for:
5.8.1. Following the procedure as outlined in this document.
5.8.2. Providing support to Doctors.

5.9. **Medical and Dental Staff** are responsible for:
5.9.1. Declaring their own, or others, wrongdoing or any failure to provide good quality care.
5.9.2. Identifying concerns about conduct, capability or health and co-operating fully with a Trust investigation.
5.9.3. Reporting concerns to the Trust through the appropriate mechanism and in a timely way.
5.9.4. Identifying reasons for the concern identified.
5.9.5. Co-operating with the Trust to identify mechanisms for improvement.

5.9.6. Complying with any restrictions on practice or exclusion.
5.9.7. Participating fully in informal action or any investigation.
5.9.8. Undertaking reskilling, remediation, or any other recommended course of action for improvement.
5.9.9. Being open and honest at all times.
5.9.10. Ensuring patient safety is protected.
5.9.11. Supporting the Trust to act within the timescales required by this procedure and not occasioning any unreasonable or undue delay to the process.
5.9.12. Not raising concerns that are unfounded or in bad faith which may amount to misconduct.
5.9.13. Arranging representatives to attend in a timely way.

5.10. **The Board of Directors** is responsible for:
5.10.1. Supporting the RO in discharging their duties.
5.10.2. Supporting the Chair of the Board in appointing an appropriate Non-Executive Director to oversee the process.
5.10.3. Ensuring this procedure is followed.

5.11. **The Designated Non-Executive Board Member** is responsible for:
5.11.1. Overseeing the activities of the Case Manager to ensure momentum is maintained during the procedure.
5.11.2. Receiving reports and reviewing the continued exclusion from work of the Doctor.
5.11.3. Considering any representations from the Doctor about their exclusion or the investigation.

5.12. The Trust Management Executive will oversee the management of this procedure.

6. IDENTIFYING CONCERNS

6.1. A Trust staff member may have a concern about a Doctor which should be raised promptly as an unreasonable delay may affect the Trust's ability to address it. Concerns must be raised in an appropriate way which will generally be with a person with management responsibility or professional accountability for the Doctor concerned, a Clinical Director or the Medical Director. If in doubt, advice should be sought from Human Resources. Staff with concerns should not share their concerns more widely than reasonably necessary for the purposes of communicating the concern to the Trust and should respect the need for confidentiality.

6.2. Concerns can arise following:
6.2.1. Routine management action such as a review of performance against job plans, annual appraisal or the revalidation process.
6.2.2. Routine monitoring of data on performance and quality of care, clinical governance activities, clinical audit and other quality improvement activities.
6.2.3. Complaints or legal action about care by patients or relatives of patients.
6.2.4. Information being provided to the Trust from a regulatory body, the police or the coroner.
6.2.5. As a result of action under another Trust policy such as following an adverse outcome of a Grievance hearing, a Dignity at Work investigation or as a result of a disclosure or investigation under the Trust's Raising Concerns (whistleblowing)

policy

6.3. The following are examples of matters which the Trust may regard as being legitimate concerns (this is a non-exhaustive list):

6.3.1. Inappropriate clinical practice arising from a lack of knowledge or skills.
6.3.2. Inappropriate delegation of clinical responsibility.
6.3.3. Inadequate supervision of delegated clinical tasks.
6.3.4. Incidents where it is perceived that there is the potential to cause harm to a patient.
6.3.5. Behaviour that would amount to misconduct under the Trust's Disciplinary policy.
6.3.6. Conduct of a criminal nature.

6.4. Any concerns relating to Doctors in training grades must be discussed with the relevant educational supervisor and college or clinical tutor and with the Postgraduate Dean.

6.5. Unfounded malicious concerns can cause lasting damage to a Doctor's reputation and career prospects. Therefore, all concerns, including those made by relatives of patients or concerns raised by colleagues must be properly considered and the substance of any allegation established.

7. ACTION WHEN A CONCERN ARISES

7.1. Initial Assessment

7.1.1. When a concern has been raised the Medical Director will first assess the seriousness of the concern and if appropriate act as Case Manager or appoint a Case Manager. The Case Manager must identify the nature of the concern and assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal action. This decision should be taken in consultation with the Director of Organisational Development and Workforce and (if the role of Case Manager is delegated) the Medical Director.
7.1.2. Where a concern is considered to be minor, informal action may be deemed appropriate. This can include where an employee has raised a concern about their own performance.

7.2. Other Agencies

7.2.1. If the concern involves fraud, regard should be given to the Trust's Counter Fraud Policy
7.2.2. Where criminal action is suspected, police involvement must be considered at the earliest opportunity (see also below if criminal conduct is suspected following an investigation).
7.2.3. Where a concern relates to a patient safety incident, additional support is available via the NHS Improvement (NHSI). NHSI have produced a comprehensive flow diagram called a just culture guide for determining a course of action. The just culture guide can be found on NHSI's website at https://improvement.nhs.uk/resources/just-culture-guide/ (see appendix 2)

7.3. Practitioner Performance Advice (PPA)

7.3.1. Where a concern arises, advice from Practitioner Performance Advice (PPA) formerly the National Clinical Assessment Service – NCAS, must be sought at the outset of the matter, when restrictions or exclusion is being considered and when the Case Manager is deciding on what if any further action is required following an investigation. To ensure confidentiality the identity of the Doctor should not be disclosed. The PPA website is https://resolution.nhs.uk/services/practitioner-performance-advice/

7.4. Duty to Co-operate

7.4.1. It is in the interests of individual Doctors and the Trust to ensure the procedures set out in this document are carried out efficiently and without unnecessary delay. Both parties will reasonably cooperate at all times to ensure that this occurs. If the Doctor unreasonably refuses to engage in the procedures outlined in this document that may lead to further disciplinary action being taken against the Doctor.

7.5. Restrictions or Exclusions from Practice

7.5.1. When serious concerns are raised about a Doctor, consideration must be given to 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 Doctor from the workplace. Where there are concerns about a Doctor in training, the Postgraduate Dean should be involved as soon as possible.

7.5.2. Exclusion of Doctors from the workplace is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.

7.5.3. The purpose of exclusion is:

7.5.3.1. To protect the interests of patients or other staff; and/or

7.5.3.2. To assist the investigative process when there is a clear risk that the Doctor's presence would impede the gathering of evidence.

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

7.5.5. Alternative ways to manage risks, avoiding exclusion, include:

7.5.5.1. Medical or Clinical Director supervision of normal contractual clinical duties.

7.5.5.2. Restricting the Doctor to certain forms of clinical duties.

7.5.5.3. Restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling.

7.5.5.4. Sick leave for the investigation of specific health problems.

7.5.6. A Doctor must not be excluded for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. The Case Manager, the Medical Director and the Board have responsibility for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged

7.6. **Immediate Exclusion**

7.6.1. An immediate time limited exclusion may be necessary:
7.6.1.1. To protect the interest of patients or other employees; and/or
7.6.1.2. To assist the investigation process when there is a clear risk that the Doctor's presence would impede the gathering of evidence.
7.6.2. It may occur following:
7.6.2.1. A critical incident when serious allegations have been made; or
7.6.2.2. A breakdown in relationships between a colleague and the rest of the team; or
7.6.2.3. A concern that the presence of the Doctor is likely to hinder the investigation.

7.6.3. Such exclusion will allow a more measured consideration to be undertaken and wherever possible PPA should be contacted for advice prior to any exclusion. This period should also be used to carry out a preliminary situation analysis and contact PPA for advice, if they have not already been contacted. The manager making the exclusion must explain 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 at which the Doctor should return to the workplace for a further meeting. The Case Manager must advise the Doctor of their rights, including the right to representation.

7.7. **Formal Exclusion**

7.7.1. A formal exclusion may only take place after the Case Manager has first considered whether there is a case to answer and whether there is reasonable and proper cause to exclude. PPA must be consulted where formal exclusion is being considered. A preliminary report prepared by the Case Investigator (Appendix 1 includes guidance regarding the preliminary report) is advised to enable the Case Manager to decide on the next steps as appropriate.

7.7.2. Formal exclusion of one or more Doctors must only be used where:
7.7.2.1. There is a need to protect the interest of patients or other employees pending the outcome of a full investigation of:
7.7.2.1.1. Allegations of misconduct.
7.7.2.1.2. Concerns about serious dysfunctions in the operation of clinical service.
7.7.2.1.3. Concerns about lack of capability or poor performance.
7.7.2.1.4. Seriousness to ensure if it is warranted to protect patients.
7.7.2.2. Formal exclusion may also take place if the presence of the Doctor in the workplace is likely to hinder the investigation.
7.7.2.3. Full consideration should be given to whether the Doctor could continue in or (in cases of immediate exclusion) return to work in a limited capacity or as an alternative, possible non-clinical role, pending the resolution of the case.
7.7.2.4. When the Doctor is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegation or areas of concern should be conveyed to the Doctor. The Doctor should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the Doctor should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to Occupational Health, referral to PPA with voluntary restriction).

7.7.2.5. 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 (e.g. exclusion from the premises and the need to remain available for work) and that a full investigation or what other action will follow. The Doctor and their companion should be advised that they may make representations about the exclusion to the Designated Non-Executive Board Member at any time after receipt of the letter confirming the exclusion.

7.7.2.6. In cases when disciplinary procedures are being followed, exclusion may be extended for four-week renewal periods until the completion of disciplinary procedures if a return to work is considered inappropriate. The exclusion should usually be lifted, and the Doctor allowed back to work, with or without conditions placed upon the employment, as soon as the original reason for exclusion no longer applies.

7.7.2.7. If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (e.g. because of a police investigation), the case must be referred to PPA for advice as to whether the case is being handled in the most effective way and advice about possible ways forward. However, even during this prolonged period the principle of four week ‘renewal’ must be adhered to.

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

7.8. Exclusion from Premises

7.8.1. Case Managers must always consider whether exclusion from the premises is absolutely necessary. There are certain circumstances, however, where the Doctor should be excluded from the premises, for example, where there may be a danger of interfering with evidence, or where the Doctor may be a serious potential danger to patients or other employees. The Doctor may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training which in many circumstances may be allowed.

7.9. Keeping in contact and availability for work

7.9.1. Exclusion under the procedure should usually be on full pay and the Doctor must remain available for work with the Trust during their normal contracted hours. The Doctor must inform the Case Manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their manager’s consent to continuing to undertake such work or to take annual leave or study leave. The Doctor should be reminded of this contractual obligation but would be given 24 hours’ notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the Doctor is no longer available

for work (e.g., abroad without agreement). They must gain permission from the Case Manager to take annual or study leave.

7.9.2. The Case Manager should make arrangements to ensure that the Doctor can keep in contact with colleagues about professional developments and take part in Continuing Professional Development (CPD) and clinical audit activities with the same level of support as other Doctors. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

7.10. **Informing Other Organisations**

7.10.1. In cases where there is concern that the Doctor may be a potential danger to patients, the Trust 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) may be readily available from job plans, but where it is not the Doctor 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 the Trust has placed restrictions on practice the Doctor should agree not to undertake any work in that area of practice with any other employer.

7.10.2. Where the Case Manager believes that the Doctor is practicing in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the Director of Public Health to consider the issue of an alert letter.

7.11. **Informal exclusion**

7.11.1. No Doctor should be excluded from work other than through this procedure, “informal exclusion” or so called “garden leave” may not be used as a means of resolving a problem covered by this procedure.

8. REVIEW OF EXCLUSIONS

8.1. **Informing the Board**

8.1.1. The Board must be informed about the exclusion of a Doctor at the earliest opportunity. The Board has a responsibility to ensure the Trust’s procedures are being followed. It should, therefore:

8.1.1.1. Require a summary of the progress of each case at the end of each period of exclusion, 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.

8.1.1.2. Receive a monthly statistical summary showing all exclusions with their duration and number of times exclusion has been reviewed and extended.

8.1.2. 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.

8.1.3. It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panels. 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 Non-Executive Board

Member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interest of patients, other employees, the Doctor, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the Doctor returning to limited or alternative duties where practicable.

8.1.4. The report to the Board should be advisory and it would be for the Case Manager to decide on the next steps as appropriate. The exclusion should usually be lifted, and the Doctor allowed back to work, with or without conditions placed upon the employment, at any time if the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The exclusion will lapse, and the Doctor will be entitled to return to work at the end of the four-week period if the exclusion is not actively renewed. 46.

8.1.5. After three exclusions PPA should be contacted.

8.2. **First and second reviews (and reviews after the third review)**

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

8.2.2. The Case Manager decides on next steps as appropriate. Further renewal may be for up to four weeks at a time.

8.2.3. The Case Manager submits advisory report of outcome to Chief Executive and the Board.

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

8.2.5. The Doctor must be sent written notification of the renewal on each occasion. 48. If the Doctor has been excluded for three periods:

8.2.6. A report must be made to the Chief Executive: outlining the reasons for the continued exclusion and 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.

8.2.7. The case must formally be referred to PPA explaining:

8.2.7.1. Why continued exclusion is appropriate; and

8.2.7.2. What steps are being taken to conclude the exclusion at the earliest opportunity.

8.2.8. PPA will review the case and advise the Trust on the handling of the case until it is concluded.

8.3. **Six Month Review**

8.3.1. Normally there should be a maximum limit of six months exclusion, except for in cases involving criminal investigations of the Doctor concerned. The Trust should actively review those cases at least every six months and discuss with PPA.

8.4. **Support during exclusion**

8.4.1. The Case Manager is responsible for offering support to the Doctor during their period of exclusion. The Case Investigator is responsible for alerting the Case Manager if further or alternative support is necessary, e.g. referral to Occupational Health or access to professional support.

8.5. **Return to Work**

8.5.1. If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the Doctor. It must be clear whether clinical and other responsibilities are to remain unchanged or what the duties and restrictions are to be. The Case Manager will consider, and arrange if appropriate any periods of coaching, training and any monitoring arrangements to ensure patient safety.

8.6. **Investigation Process**

8.6.1. As promptly as possible after the decision to carry out a formal investigation is taken the Doctor should be notified by the Case Manager. A meeting between the Case Manager and the Doctor should be held and the following confirmed in writing:

8.6.1.1. The fact that an investigation is to be carried out.

8.6.1.2. The specific allegations or concerns.

8.6.1.3. The name of the case investigator and where relevant any clinical adviser.

8.6.1.4. If known, the list of people to be interviewed by the case investigator. This must be kept under review and updated as appropriate.

8.6.1.5. The Doctor's right to meet the case investigator to put forward their views and any evidence.

8.6.1.6. Their right to be represented

8.6.1.7. Their right to be given the opportunity to see any correspondence relating to the case.

8.6.2. The name of the Non-Executive Director overseeing the case.

8.7. **Right to Representation**

8.7.1. The right to be represented extends to any of the meetings or hearings referred to throughout this document. It also extends to a Doctor when the concern is related to conduct which is dealt with under the Trust's Disciplinary Procedure. The Doctor may be represented by a friend, partner/spouse, work colleague or Trade Union/defence organisation representative. There is a right to a legal representative instructed or employed by a defence organisation. Other representatives may be legally qualified but will not be permitted to act in a legal capacity during any of the proceeding. The representative will be entitled to present the case on behalf of the Doctor, address the panel and question the management case and any witness evidence, but will not have a right to answer questions on the Doctor's behalf.

8.8. **The Case Investigator**

8.8.1. Must be appropriately experienced and/or trained.

8.8.2. Should be supported by an experienced/ trained HR professional.

8.8.3. Has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner.

8.8.4. If the Case Investigator is not a clinician, or specific specialised clinical expertise is required at any stage of the investigation, the Case Manager must appoint a clinical advisor to assist the Case Investigator, if an issue of clinical judgment is

raised.

8.8.5. The Case Investigator must:

8.8.5.1. Establish a detailed factual account of the relevant events or circumstances.

8.8.5.2. Take all appropriate steps to safeguard the confidentiality of the investigation including but not limited to; restricting discussion of the matter to necessary parties only; instructing others to safeguard confidentiality; ensuring the physical security of documents at all times; redacting information that might identify patients; redacting any information in relation to the medical history of patients not strictly required for the purposes of the investigation; using password protection/encryption in relation to all documents and correspondence;

8.8.5.3. Notify the Doctor of her/his appointment in writing and at that time provide them with:

8.8.5.3.1. Details of timescales

8.8.5.3.2. Details of all anticipated witnesses.

8.8.5.3.3. Copies of correspondence and documents relevant to the investigation.

8.8.5.3.4. A reminder of the right to be represented at all meetings.

8.8.5.3.5. Keep the Doctor informed of the progress of the investigation.

8.8.5.3.6. Search for and collate any documentary evidence relevant to the investigation.

8.8.5.3.7. Interview all relevant witnesses and obtain a signed witness statement of the evidence which each witness can provide.

8.8.5.3.8. Keep under review at all times the list of witnesses who need to be spoken and ensure witnesses are not overlooked.

8.8.5.3.9. Ensure that the Doctor has an opportunity to direct the investigation to any evidence or witness that they believe is relevant.

8.8.5.3.10. Ensure that there is a reasonable attempt to look for exculpatory evidence and not simply evidence of wrongdoing or failure.

8.8.5.3.11. Work in conjunction with and take appropriate note of the expert views of any clinical expert appointed to support the investigation.

8.8.5.3.12. Seek further guidance from the Case Manager before proceeding in the event that any new concerns (whether of conduct or capability) are identified which are not reflected in the Terms of Reference.

8.8.5.3.13. Provide a written report (see Appendix 1) which should have appended to it all witness statements and documentary evidence which should be arranged in strict chronological order. The report should provide sufficient information to allow the Case Manager to make a decision on any further action.

8.9. **Timescales**

8.9.1. The Case Investigator should normally complete their investigation within four weeks of their appointment and submit the report to the Case Manager within a further 5 working days.

8.9.2. In circumstances where a Case Investigator cannot meet the four-week target, as soon as this is realised, they should notify the Case Manager, who in turn will notify the Doctor and explain why.

9. ACTION BY THE CASE MANAGER ON RECEIPT OF THE REPORT

9.1. The Case Manager must provide the Doctor the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the Doctor, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of the receipt of the request for comments.

9.2. The Case Manager will review the investigation report.

9.3. The Case Manager must seek advice from PPA.

9.4. The Case Manager will make a decision about any further action. Options following consideration of investigation report include:

9.4.1. No further action required.

9.4.2. A Centre for Occupational Health and Wellbeing referral, if there are concerns regarding the Doctor's health.

9.4.3. Informal processes to correct performance, with the assistance of PPA if appropriate.

9.4.4. Measures to support the Doctor such as rehabilitation, remediation, and reskilling.

9.4.5. Instigate the Trust's Discipline and Conduct policy.

9.4.6. Instigate action under the parts of this procedure that address capability. In the event of a disagreement about the categorisation of the doctor, disputes will be resolved under the grievance procedure.

9.4.7. Restriction or exclusion of practice if not already occurred.

9.4.8. Review of Trust system and / or process failures and ensuring that these are rectified at the earliest opportunity, including the retraining of staff where appropriate.

9.4.9. Determine what further monitoring is required of the Doctor.

9.5. In the event of an overlap between issues of conduct and capability, then usually both matters will be heard under the capability procedure. In exceptional circumstances, it may be necessary for issues to be considered under separate procedures. The decision as to which procedure shall be initiated shall be taken by the Case Manager in consultation with the Director of HR & OD and PPA. If a Doctor considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the Trust's Grievance Procedure. Alternatively, or in addition, he or she may make representations to the Designated Non-Executive Board member.

9.6. As soon as the decision is made, the Case Manager should inform the Doctor, in writing, of the reasons for the decision.

9.7. Criminal acts

9.7.1. Where the Trust's investigation establishes a suspected criminal action, consideration must be given to reporting to the police. The Trust investigation should only proceed in respect of those aspects of the case which are not directly related to the police investigation. The Trust must consult with the police to establish whether an investigation into any other matters would impede their investigation.

9.7.2. In cases of fraud, the Counter Fraud & Security Management Service must be

contacted.

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

9.7.4. When the Trust has refrained from taking action pending the outcome of a court case and the Doctor is acquitted after trial, or the case is discontinued 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. Similarly, where there are insufficient grounds for bringing criminal charges, or the Doctor is acquitted after trial or the case is discontinued, there may still be grounds to take action where the allegation would, if proved, constitute misconduct.

9.8. **Conduct Procedure**

9.8.1. If the Case Manager finds that there is a case of misconduct to answer, then the matter should be dealt with using the Trust's Disciplinary Procedure applicable to all employees. The Doctor shall have the additional right to be represented in line with the terms of this procedure. Any appeal under the Disciplinary Procedure should be dealt with using the Trust's Appeals Procedure and there is no other right of appeal.

9.9. **Capability Procedure**

9.9.1. Consideration must be given as to whether any failure or concern in relation to a Doctor was due to broader systems or organisational failure.

9.9.2. If the concerns relate to the capability of an individual Doctor, these should be dealt with under this procedure whether arising from a one-off or series of incidents.

9.9.3. Wherever possible, issues of capability shall be resolved through on-going assessment, retraining and support. If the concerns cannot be resolved routinely by management, NPPA must be contacted for support and guidance before the matter can be referred to a capability panel.

9.9.4. Any concerns relating to Doctors in training grades must be discussed with the relevant educational supervisor and college or clinical tutor and with the Postgraduate Dean from the outset.

9.10. **Pre-Capability Hearing Process**

9.11. Once the Case Investigator has concluded their investigation the report will be sent to the Case Manager. The Case Manager will already have provided the Doctor with the opportunity to comment on the factual sections of the report.

9.12. The Case Manager shall decide on the action that needs to be taken, consult with PPA and within 10 working days notify the Doctor in writing on how the issue is to be dealt with.

9.13. The options available to the Case Manager for dealing with the matter are:
9.13.1. No action required.
9.13.2. Opportunities identified for development.
9.13.3. Training, retraining or job counselling should be undertaken.
9.13.4. Rehabilitation services to be offered where appropriate.
9.13.5. Refer to PPA for clinical assessment.
9.13.6. Referral to a capability panel for a hearing.

9.14. Where the reason for concern is linked to failures in Trust systems or procedures, this should be rectified immediately, and training put in place to ensure understanding and compliance.

9.15. **Panel Members**

9.15.1. The panel for the capability hearing shall consist of at least three people including:
9.15.1.1. An Executive Director of the Trust (who will normally act as chairperson);
9.15.1.2. A Board Member or Senior Manager of the Trust.
9.15.1.3. A Doctor, in the same or similar clinical speciality, not employed by the Trust.
9.15.1.4. If the Doctor is a Clinical Academic, a further panel member may be appointed in accordance with any agreed protocol between the Trust and the University.

9.15.2. The panel will also be advised by a senior member of the Human Resources team.

9.15.3. The Doctor should be notified of the panel members in writing by the Case Manager, where possible at the same time as the notification of the hearing.

9.16. **Time limits**

9.16.1. Within 5 working days of their notification, the Doctor should raise with the Case Manager any objections to the panel members. The Case Manager in consultation with the Trust's Director of Organisational Development and Workforce shall consider the objections and will respond in writing prior to the hearing, stating the reasons for any decision on the objections. Reasonable efforts will be made by the Trust to agree the composition of the panel and only in exceptional circumstances shall the hearing be postponed whilst the matter is resolved.

9.16.2. Where a Case Manager has decided to refer the matter to a capability panel, the following preparatory steps must take place:
9.16.2.1. 20 working days before the hearing the Case Manager will notify the Doctor in writing of the decision to arrange a capability hearing.
9.16.2.2. The Doctor must at the same time be provided with details of the allegations and copy documents or evidence that will be put before the capability panel and confirmation of their right to be represented.
9.16.2.3. At least 10 working days before the hearing, both parties should exchange documents (including any written statements of case) and witness statements on which they intend to rely at the hearing. In the rare circumstance where either party intends to rely on a witness but does not have a witness statement, they must provide a written synopsis of the evidence that witness will provide.

This synopsis must contain the key elements of the witness evidence and be provided at least 10 working days before the hearing.

9.16.2.4. At least 5 working days before the hearing, the parties must exchange final lists of witnesses they intend to call to the hearing. The Chairman of the panel can invite the witness to attend where a witness' evidence is in dispute. If the witness is unavailable or unable to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it. Witnesses may be accompanied to the hearing but the person accompanying them may not participate in the hearing. Where only a synopsis of the witness' evidence has been provided in advance, reduced weight will be given to the account unless the synopsis of evidence has been explicitly agreed by the other party.

9.16.3. In the event of late evidence being presented, the Chairman of the panel should give consideration as to whether a new date for the hearing will be set or to proceed as scheduled.

9.17. **Postponement Requests**

9.17.1. In the event of a postponement request, the Case Manager shall deal with the response and may agree time extensions. If the Doctor requires a postponement of over 30 working days, the Chairman of the capability panel should consider the grounds for the request and if reasonable to do so may decide to proceed with the hearing in the Doctor's absence.

9.18. **Sickness Absence**

9.18.1. Where during the capability procedure a Doctor becomes ill, their sickness absence may be managed under the Trust's Absence Management Procedure. The Trust may not be precluded from concluding conduct/capability proceedings in relation to the Doctor during any period of sickness absence.

9.18.2. If a hearing proceeds in the absence of a Doctor by reason of ill-health, the Doctor will have the opportunity to submit written statements and/or have a representative attend in their absence.

9.19. **Termination of Employment**

9.19.1. If a Doctor leaves the Trust's employment prior to the conclusion of the conduct/capability proceedings, the proceedings must be completed wherever possible. This applies whatever the personal circumstances of the Doctor.

9.19.2. If the Doctor cannot be contacted via their last known address/registered address or refuse to participate in proceedings, the Trust will need to make a decision on the capability issues raised based on the evidence it has and take appropriate action. This decision shall be made by the Chief Executive in conjunction with the Case Manager, Director of Organisational Development and Workforce and in consultation with the Designated Non-Executive Board Member. This action may include a referral to the GMC/GDC, the issue of an alert letter by PPA following referral to them and/or referral to the police

9.20. **The Capability Hearing**

9.20.1. The Chairman of the panel is responsible for ensuring the hearing is conducted properly and in accordance with the Trust's procedure.

9.20.2. The Doctor has the right to be represented at the hearing as set out above. The hearing is not a court of law and should not be conducted in a legalistic or overly formal manner.

9.20.3. At all times during the hearing the panel, its advisers, the Doctor, their representative and the Case Manager must be present. A witness will only be present whilst giving evidence.

9.20.4. The procedure for the hearing will be as follows:

9.20.4.1. The Case Manager presents the management case (which may be by reference to the Case Investigator's report or a separate statement of case).

9.20.4.2. The Case Manager will call witnesses in turn. Each will confirm their witness statement and provide any additional information. The Case Manager may ask additional questions. The Doctor's representative may ask questions of the witnesses (if unrepresented the Doctor may ask questions). The panel may question the witness. The Case Manager may then ask further questions to clarify any point but will not be able to raise new evidence.

9.20.4.3. The Chairman may ask the Case Manager to clarify any issues arising from the management case.

9.20.4.4. The Doctor and/or their representative shall present their case and call any witnesses. The above procedure used for the Case Manager's witnesses shall be followed.

9.20.4.5. The Chairman can request any points of clarification on the Doctor's case.

9.20.4.6. The Chairman shall invite the Case Manager to make a short closing statement summarising the key points of the management's case.

9.20.4.7. The Chairman shall invite the Doctor and/or their representative to make a short closing statement summarising the key points of their case. Where appropriate, this should include any grounds of mitigation.

9.20.4.8. The panel shall retire to consider its decision.

9.21. **The Decision**

9.21.1. The panel has the discretion to make a range of decisions including:

9.21.1.1. No action required as allegations unfounded.

9.21.1.2. Verbal agreement by the Doctor that there will be an improvement in performance within a specified timescale confirmed in a written statement as to what is required and how it is to be achieved.

9.21.1.3. Written warning to improve performance within a specified timescale and actions required to achieve improvement.

9.21.1.4. A final written warning that there must be improved performance within a specified timescale and how this can be achieved.

9.21.1.5. Termination of employment.

9.21.2. The decision must be confirmed in writing to the Doctor within 5 working days of the hearing and communicated to the Case Manager within the same timescale. The letter to the Doctor must include reasons for the decision, confirmation of the right of appeal and notification of any intention to make a referral to the GMC/GDC or any other external professional body.

9.21.3. An appeal must be made in writing, stating the full grounds of appeal, within 25

working days of the hearing. The appeal should be addressed to the Director of Organisational Development and Workforce.

9.21.4. Any decision must be placed in the Doctor's personal file. As general guidance a verbal agreement should remain on the file for six months and written warnings for twelve months.

10. CAPABILITY APPEAL PROCEDURE

10.1. Remit of the Appeal Panel

10.1.1. This appeal procedure shall relate to decisions of a capability panel. The remit of the appeal panel is to review the decision taken by the capability panel and to assess whether it was fair and reasonable and commensurate with the evidence heard. It will also review the procedure followed by the capability panel. A full re-hearing of all evidence should not take place unless the Chairman of the appeal panel considers that proper procedures have not been followed at an earlier stage in the process and a full rehearing is required in the interests of a fair process.

10.1.2. The appeal panel can hear any new evidence submitted by the Doctor to consider whether this might have significantly altered the capability panel's decision. The Case Manager may call new evidence that is relevant to new evidence called by the Doctor and/or his or her representative.

10.2. The Appeal Panel

10.2.1. The appeal panel should consist of three members. The members of the 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 Non-Executive Board Member. These members will be:

10.2.1.1. An appropriately skilled external independent member. This person is designated Chair.

10.2.1.2. The Chairman of the Trust (or another Non-Executive Director).

10.2.1.3. A medically/dentally qualified member who is not employed by the Trust.

10.2.1.4. Where the Doctor is a Clinical Academic, a further panel member may be appointed in accordance with any agreed protocol between the Trust and the relevant University.

10.2.2. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.

10.2.3. The appeal panel may be advised by:

10.2.3.1. Consultant from the same specialty or sub-specialty of the Doctor who is not employed by the Trust.

10.2.3.2. A senior Human Resources professional.

10.2.4. The panel will be established by the Trust in its discretion and advice may be sought from the Director of Organisational Development and Workforce.

10.2.5. The Doctor shall be notified of the composition of the panel, where possible, 25 working days prior to the hearing. If the Doctor objects to a panel member, the Director of Organisational Development and Workforce shall liaise with them or their representative to seek to reach agreement. In the event agreement cannot be reached, the objections will be noted carefully.

10.2.6. The following steps shall be taken:

10.2.6.1. Within 25 working days of the Doctor receiving the capability panel's decision

they must send an appeal statement to the Trust's Director of Organisational Development and Workforce giving full grounds for the appeal.

10.2.6.2. Within 25 working days of the appeal being lodged, the appeal hearing shall take place.

10.2.6.3. At least 10 working days before the appeal hearing, the appeal panel shall notify the parties if it considers it is necessary to hear evidence from any witnesses not called by either party and provide them with written statements from any such witnesses at the same time.

10.2.6.4. At least 10 working days before the hearing the Doctor shall confirm to the panel and the Case Manager whether they have any additional evidence on which they intend to rely. Copies of any documents or witness statements shall be provided with the notice of intention to call additional evidence.

10.2.7. At least 10 working days before the hearing, the Case Manager shall confirm to the panel and the Doctor whether they have any additional evidence on which they intend to rely. Copies of any documents shall be provided. If the Case Manager's response to the Doctor's grounds of appeal is other than as set out in the written decision of the capability panel, the Case Manager must provide this response, in written form, to the Doctor no later than 5 working days before the appeal hearing.

10.3. **Appeal Hearing Procedure**

10.3.1. The procedure for the hearing will be as follows:

10.3.1.1. The Doctor or their representative shall present a full statement of their case to the appeal panel which shall include all the grounds of appeal.

10.3.1.2. The Presenting Manager and the panel shall be entitled to question the Doctor or his representative on the grounds of appeal.

10.3.1.3. The Doctor or their representative shall present any additional evidence/witnesses. If they do so, the Presenting Manager and panel may ask questions.

10.3.1.4. The Presenting Manager shall submit a statement of the management case to the appeal panel which shall include the response to the grounds of appeal.

10.3.1.5. The Doctor and the appeal panel shall be entitled to question the Presenting Manager.

10.3.1.6. The Presenting Manager shall submit any additional evidence/witnesses in relation to any new evidence from the Doctor or their representative, submitted at the appeal stage. The Doctor or their representative and the panel may ask questions.

10.3.1.7. The Presenting Manager shall sum up their case.

10.3.1.8. The Doctor or their representative shall sum up their case. At this stage a mitigation statement may be made.

10.3.1.9. The appeal panel shall retire to make a decision

10.4. **The Decision of the Appeal Panel**

10.4.1. The appeal panel may:

10.4.1.1. Confirm the original decision of the capability panel.

10.4.1.2. Amend the decision of the capability panel; however, this cannot result in a higher sanction to the original decision.

10.4.1.3. Order the case to be reheard in its entirety.

10.4.2. The appeal panel's decision and the reasons for it must be confirmed in writing to the Doctor within 5 working days of the appeal hearing. A record of the decision shall be kept on the Doctor's personal file including a statement of the capability issues, the action taken and the reasons for those actions.

10.4.3. Where the appeal is about the Doctor's dismissal, they will not be paid from the date of termination as decided by the original capability panel. If the Doctor is reinstated following the appeal their pay shall be backdated to the date of termination of employment

10.4.4. If the appeal panel decided that the whole case is to be reheard, the Doctor shall be reinstated and be paid backdated salary to the date of termination. In this situation any conditions/restrictions on practice in place at the time of the original capability hearing shall be reviewed and applied as appropriate.

11. HANDLING CONCERNS ABOUT A DOCTOR'S HEALTH

11.1. 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 workplace factors such as stress.

11.2. The 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.

11.3. Retaining the services of individuals with health problems

11.3.1. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk.

11.4. Examples of action to take

11.4.1. Authorised sick leave for the Doctor (the Doctor to be contacted frequently on a pastoral basis to stop them feeling isolated);

11.4.2. Remove the Doctor from certain duties.

11.4.3. Reassign to a different area of work.

11.4.4. Arrange re-training or consider and implement reasonable adjustments to their working environment, with appropriate advice from PPA and/or the Deanery, under the Equality Act 2010.

11.5. Reasonable adjustment

11.5.1. At all times the Doctor should be supported by the Trust the Occupational Health who should ensure that the Doctor is offered every available resource to get back to practice where appropriate. The Trust should consider what reasonable adjustments could be made to their workplace conditions or other arrangements. Examples of reasonable adjustments include: -

11.5.1.1. Make adjustments to the premises.

11.5.1.2. Re-allocate some of the Doctor's duties to another.

11.5.1.3. Transfer employee to an existing vacancy.

11.5.1.4. Alter Doctor's working hours or pattern of work.
11.5.1.5. Assign Doctor to a different workplace.
11.5.1.6. Allow absence for rehabilitation, assessment or treatment.
11.5.1.7. Provide additional training or retraining.
11.5.1.8. Acquire/modify equipment.
11.5.1.9. Modifying procedures for testing or assessment.
11.5.1.10. Provide a reader or interpreter; and/or
11.5.1.11. Establish mentoring arrangements.

11.5.2. In some cases, retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures where appropriate

11.6. **Handling Health Issues**

11.6.1. Where there is an incident that points to a problem with the Doctor's health, the incident may need to be investigated to determine a health problem. If the report recommends Centre for Occupational and Wellbeing's involvement, the nominated manager must immediately refer the Doctor to a qualified, usually Consultant, Occupational Health Physician.

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

11.6.3. The Occupational Health Physician should agree a course of action with the Doctor and send their recommendations to the Medical Director and a meeting should be convened with the Director of HR & OD, the Medical Director or Case Manager, the Doctor and case worker from the OH to agree a timetable of action and rehabilitation, where appropriate.

11.6.4. The Doctor may wish to bring a 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.

11.6.5. If a Doctor's ill health makes them a potential 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 must be considered and the professional regulatory body must be informed, irrespective of whether or not they have retired on the grounds of ill health.

11.6.6. In those cases where there is impairment of performance solely due to ill health, disciplinary procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the Trust to resolve the underlying situation e.g., by repeatedly refusing a referral to the Centre for Occupational Health and Wellbeing or PPA. In these circumstances the capability procedure should be followed.

11.6.7. There will be circumstances where a Doctor 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 is expected to refer the Doctor to the Centre for Occupational Health and Wellbeing for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, Occupational Health under these circumstances, may give separate grounds for pursuing disciplinary action.

APPENDIX 1: CASE INVESTIGATOR'S REPORT GUIDELINES

The report needs to set out the case story and include chapter headings with page numbers, as demonstrated below. Each document referred to should have a unique identifier and where there are many documents it may be helpful to categorise them by type – witness statement, clinical record, summary of witness interview.

A suggested structure for the investigation report is shown below.

1. FRONT COVER

- Strictly Confidential
- South Central Ambulance Service Foundation Trust (SCAS)
- Report of investigation into concerns raised in relation to Doctor's name, job title and department
- Case reference number, if applicable.
- Name and job title of Case Investigator
- Date

2. INTRODUCTION

2.1 A brief introduction to the investigation, its relationship with any investigations by other bodies and the procedures and regulations governing the present investigation.

2.2 The investigation report must be written with the full input of the clinical adviser where there is one. The key is to prepare a clear and thorough report which the Case Manager can understand and present at a hearing.

3. BACKGROUND INFORMATION

3.1. Relevant career information about the Doctor and their role within the Trust.

3.2. The circumstances leading to the investigation. This may include a summary of the incidents of concern and a description of how they came to the attention of the Trust's senior management.

3.3. The specific allegations for investigation, the Terms of Reference (signed and dated by the Case Manager) as set initially plus any subsequent amendments.

3.4. Names, job titles and qualifications of the team carrying out the investigation.

4 METHODOLOGY

4.1 The report should clearly set out the stages of the investigation, which witnesses were interviewed, what documentation was considered and appended as appropriate and where applicable, what link up there was with those carrying out a Serious Incident Review Investigation (SIRI) into the same matter and detail any other steps that were taken in the course of the investigation.

4.2 f any expert witnesses were used, their expert credentials should be reported.

5 FINDINGS OF FACT

5.1 What has happened, set out in chronological order and with supporting evidence identified.

5.2 Where the findings of fact include the opinion of the Case Investigator or other experts on a standard of care, the required standards of care should be quoted.

5.3 The report should set out the main evidence gathered in respect of each of the

concerns investigated, in line with the Terms of Reference. Then set out the findings of fact concern by concern giving evidence to substantiate the concern. The response to the concern should also be recorded. The Case Investigator needs to show that they have fully investigated all of the Terms of Reference.

5.4 Where there is conflict of evidence, this is reported as a finding of fact, the Case Investigator should explain which evidence appears preferable and why that is the case. However, this may not always be necessary. It depends whether such disputes need to be resolved in order to make findings.

5.5 The finding of fact in respect of each concern should be set out. If there are other explanations or mitigating factors working which are relevant to these findings of facts, these should also be identified. For instance, evidence of a systems failure.

6. CONCLUSIONS

The conclusions reached on each of the points listed in the terms of reference, cross referenced to the findings of fact.

7. APPENDICES

7.1 Appended to the report should be;

7.1.1 Copies of the signed and dated statements gathered in the course of the investigation.

7.1.2 All documents considered by the Case Investigator. These should be organised in chronological, paginated order with the oldest documents first with an index at the start. In some cases, it may make matters easier if documents are sorted by individual issue and then chronologically.

7.1.3 The appendix should be prepared as a separate bundle of documents for ease of reference, especially where there are a lot of documents

8. PRELIMINARY REPORT

8.1 If requested by the Case Manager, the Case Investigator may be asked to produce a preliminary report. The preliminary report is advisory to enable the Case Manager to decide on next steps. The report will be used by the Case Manager in order for them to make a determination on the issue of formal exclusion. The preliminary report should contain the following:

8.1.1 A statement as to the concerns being investigated.

8.1.2 An explanation of what investigations have been undertaken to date.

8.1.3 An explanation of the evidence gathered to date (this can be by reference to documents or witness statements appended to the preliminary report).

8.2 The Case Investigator should present the available facts and information to allow the Case Manager to decide whether a formal exclusion is necessary. The Case Investigator may, for example, have little evidence to support the allegations against the Doctor (although this will have to be thoroughly considered in the course of a full investigation) and this should be referred to in the report. Alternatively, there may be evidence that exclusion is necessary to protect patient or staff interests or to assist the investigatory process. This information and the available evidence should be set out in the preliminary report. It will be the Case Manager's role to decide what action

should be taken.

8.3 Issues for the Case Manager to consider on reviewing report:

8.3.1 Identify the nature of the problem, are the concerns too serious to ignore?

8.3.2 If so, can they be addressed through remedial action such as the supervision of a Divisional or Clinical Director, mentorship or an PPA assessment? If not, why not?

8.4 The Case Manager needs to be careful to give an explanation as to why they recommend one course of action over another.

8.5 If the Case Manager concludes there is a serious case to be answered what allegations do, they recommend should be put before a panel.

8.6 What does the Case Manager recommend for the future management of the case?

8.7 It may be necessary to exclude or restrict the Doctor, or a temporary change of division. The Case Manager should seek advice as set out in this procedure.

8.8 Does the Case Manager recommend referring the matter to the GMC or GDC?

8.9 Are the concerns so serious that they consider an Alert Letter may be appropriate?

APPENDIX 2: A JUST CULTURE GUIDE (chart)

A just culture guide

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

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

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

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

Please note:

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

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

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

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

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

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

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

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

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

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

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

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

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

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

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

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

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

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

5a. Were there any significant mitigating circumstances?

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

If No

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

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

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APPENDIX 3: CONCERNS PROCESS FLOW CHART (chart)

M&D Concerns Process Map

South Central Ambulance Service
NHS Foundation Trust

Medical Director

Concern raised, initial assessment made by Medical Director or nominated deputy

Appoint Case Manager

Case Manager

Case Manager (CM) Considers allegations with advice from HR & PPA if necessary

Formal

Informal

Follow informal process

CM produces terms of reference (TOR)

Is exclusion or temporary change/ restrictions to duties appropriate?

No

Yes

Follow exclusion process

CM appoints Case Investigator (CI), who, where appropriate, produces a Preliminary Investigation Report

CM advises the Doctor in writing:

- Of any exclusion/restrictions to practice;
- That an investigation is to be undertaken;
- The name of the CI;
- The specific concerns or allegations that have been raised.

CM invites the Doctor to comment in writing on the factual content of the report, including any mitigation, to be submitted to the CM within 10 working days.

CM reviews the report and decides next course of action

Case to answer?

No

CM informs Dr of no further action

Yes

How Should matter be dealt with

Informal

Follow informal process

Formal

Is ongoing exclusion or temporary change/ restrictions to duties appropriate?

No

Yes

Follow exclusion process

Is the issue solely a matter of conduct?

No

If capability involved, follow Capability Procedure (as per this procedure)

CM advises Doctor that the Capability Procedure is being followed

Yes

Follow Trusts Discipline procedure

Case Investigator

CI, supported by HR professional and where appropriate a clinical advisor, undertakes an investigation to ascertain the facts in an unbiased manner.

CI concludes investigation within 4 weeks of appointment and submits report to CM within a further 5 working days

CI sends completed investigation report to CM

Start of process

End of process