East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST WIDE DOCUMENT

	Policy
DOCUMENT TITLE	**RESPONDING TO CONCERNS ABOUT CLINICAL PERFORMANCE**
DOCUMENT NUMBER	**ELHT/HR39 Version 5.2**
DOCUMENT REPLACES	**ELHT/HR39 Version 5.1** **ELHT/HR66 Version 1.6**
LEAD EXECUTIVE DIRECTOR DGMS	• **Executive Medical Director** • **Executive Director of Human Resources & Organisational Development**
AUTHORS	• **Deputy Medical Director for Professional Standards** • **Head of Human Resources**

TARGET AUDIENCE	All Medical Personnel
DOCUMENT PURPOSE	The policy describes the locally agreed pathway for responding to concerns including the mechanism for establishing the level of concern, and ensuring the resulting actions are appropriate and proportionate.
To be read in conjunction with	• Trust Disciplinary Policy (HR 09) • Trust Sickness Absence Policy (HR 06)

SUPPORTING REFERENCES	• Maintaining High Professional Standards in the Modern NHS (DoH, 2005). • Good Medical Practice (GMC, 2019) • Standards for Dental Professionals (GDC, 2013) • A practical guide for responding to concerns about medical practice" NHS England March 2019 • Dido Harding recommendations available at: https://i.emlfiles4.com/cmpdoc/9/7/2/8/1/1/files/56794_letter-to-chairs-and-chief-executives-24-may-2019.pdf (Appendix 1)

CONSULTATION		
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AMENDMENTS	Minor amendments • Section 3.11 • Section 28 • Appendix 6	

Table of Contents

1. INTRODUCTION

1.1 The Responsible Officer has a statutory duty in relation to investigating, monitoring and responding to concerns about a doctor's practice. This policy has been developed to support the Responsible Officer to discharge their responsibilities and should be read in accordance with the national policy framework, *Maintaining High Professional Standards in the Modern NHS (Department of Health, 2003).* This policy has been developed in consultation with the Trust's Joint Local Negotiating Committee and describes the locally agreed pathway for responding to concerns including the mechanism for establishing the level of concerns, and ensuring the resulting actions are appropriate and proportionate.

1.2 The principles of good practice in handling concerns, in keeping with the recommendations by Baroness Dido Harding, 2019 (Appendix A) can be summarised as:

- Patients must be protected
- All action must be based on reliable evidence and adhere to best practice
- The process must be clearly defined and open to scrutiny
- The process should demonstrate equality and fairness
- All information must be safeguarded
- Support must be provided to all those involved
- At all stages, the practitioner will have the right to be accompanied by a companion, who is either a Trust employee, an official or lay representative of the British Medical Association (BMA) or medical defence organisation

1.3 This policy has been developed in consultation with the Trust's Joint Local Negotiating Committee and describes the locally agreed pathway for responding to concerns including the mechanism for establishing the level of concern, and ensuring the resulting actions are appropriate and proportionate.

2. SCOPE

2.4 This policy and procedure applies to all medical and dental practitioners employed by East Lancashire Hospitals NHS Trust.

2.5 Where concerns are raised about a doctor or dentist in training where ELHT is not the employer, then the Director of Medical Education will liaise with the Postgraduate Dean and the lead employer in accordance with *Maintaining High Professional Standards in the Modern NHS (Department of Health, 2003).*

2.6 Where concerns are raised about a doctor or dentist who are not connected to ELHT with the GMC (e.g. agency doctors), the Deputy Medical Director for Professional Standards will ensure the RO for the doctor is informed.

2.7 This policy provides a framework for:

- Establishing the level of concern
- Identify if an action should be taken when a concern about a doctor or dentist (hereafter referred to as practitioner) first arises which may be;
    - Informal action or remediation (Section A in this policy)
    - Formal Investigation and case management (Section B in this policy)

3. RESPONSIBILITIES

3.5 The Chief Executive

Serious concerns about a practitioner must be registered with the Chief Executive.

3.6 The Responsible Officer

The Executive Medical Director is the Trust's Responsible Officer. The Responsible Officer has a statutory obligation in relation to investigating, monitoring and responding to concerns. These duties are set out in *The Medical Profession (Responsible Officer) Regulations 2010.*

3.7 The Case Manager

A case manager is identified for all formal case investigations. The Medical Director can act as Case Manager or they will delegate the role of case manager to a Deputy Medical Director, Divisional Director or other appropriately trained individual (i.e. somebody that has attended case manager training provided by NHS Resolution). It may sometimes be appropriate to delegate the role to an appropriately trained individual outside of the Trust. The Case Manager must appoint a Case Investigator to deal with the specific case.

3.8 The Chairman of the Board

The chairman must appoint a non-executive director as "the Designated Board Member" to oversee any case that proceeds to formal investigation to ensure that it is being dealt with promptly.

3.9 The Designated Board Member

The Designated Board Member is responsible for ensuring all formal investigations are carried out fairly and promptly and may hear representations about exclusions or other matters regarding the process.

3.10 The Director of Human Resources

The Case Manager and Responsible Officer must consult with the Human Resources Director (or nominated delegate) to decide the appropriate course of action in cases of serious concern.

3.11 Professional Standards Group (PSG)

The PSG is a group who meet monthly to discuss concerns about Doctors and Dentists. The PSG is made up of a group of senior clinical and non-clinical individuals with in-depth knowledge of medical performance processes

and professional standards who are able to provide advice on handling individual cases. The PSG monitor case investigations to ensure cases are dealt with promptly and fairly in accordance with Trust policy and the national framework. The discussion for any case considered at PSG will be recorded in the minutes and may be made available to the practitioner concerned upon request unless in exceptional circumstances (such as a police investigation).

3.12 Practitioner Performance Advisory Service (PPAS)

PPAS offers advice on capability and/or conduct concerns about practitioners including restrictions and exclusions and advises on how investigations should be approached.

3.13 The Case Investigator

When a formal process is being followed, the Case Investigator is responsible for ensuring that concerns are investigated quickly and appropriately. A clear audit trail must be established for initiating and tracking the progress of the investigation and resulting action.

3.14 Practitioners

Practitioners should adhere to the standards of Good Medical Practice (GMC, 2019) and Standards for Dental Professionals (GDC, 2013). Practitioners will also demonstrate and role model the values and behavioural framework of ELHT. Practitioners must take part in continuing professional development, facilitated through annual appraisal to enhance skills and keep up to date to remain fit to practise through revalidation.

3.15 Postgraduate Dean

The Postgraduate Dean is the Responsible Officer for all Doctors and Dentists in training. Where concerns are raised about a doctor or dentist in training, the Postgraduate Dean (or nominated delegate) should be informed immediately.

3.16 Director of Medical Education

The Director of Medical Education will liaise with the Postgraduate Dean and the Lead Employer where concerns are raised about a doctor or dentist in training. The Director of Medical Education will support and manage performance concerns raised about a doctor or dentist in training.

3.17 Divisional Directors

Divisional Directors are responsible for managing informal concerns and ensuring processes for escalating concerns occur at the appropriate stage. Divisional Directors should also oversee any action plans or remediation.

3.18 Clinical Directors

Clinical Directors are responsible for identifying and managing informal concerns and escalating where appropriate.

4. POLICY STATEMENT

The majority of practitioners provide a high standard of care to patients. As medicine and technologies evolve, doctors must enhance their skills and keep up to date in order to remain fit to practise. Doctors and dentists are supported in the process of continuing professional development, which is facilitated through annual appraisal. Continuing professional development is enhanced by self-directed learning, team-based discussions and clinical governance processes led by the organisation in which they are working.

In the course of their professional career every doctor will experience variation in the level of their practice, and clinical competence. Every doctor will make mistakes and, on occasion, patients may come to harm as a result. All doctors must therefore be vigilant in recognising, and taking responsibility for mistakes and for reductions in the quality of their practise. Learning from these will improve patient safety in the future.

5. RESPONDING TO CONCERNS ABOUT A PRACTITIONER

5.1 Where a practitioner's standard of care falls below that defined within Good Medical Practice or Standards of Dental Professionals, continuing professional development measures alone may be insufficient to address the problem.

5.2 Concerns about a practitioner's practice can be separated into three categories:

- Conduct
- Capability
- Health

5.3 There is often considerable overlap between these categories and concerns may arise from any combination, or all three. Issues with health take priority. Where there is overlap between issues of misconduct and capability, this will usually be dealt with under the capability procedure.

5.4 Concerns about a practitioner can come to light in a wide variety of ways. Appendix 2 gives examples of sources and types of concern, but this is not exhaustive.

5.5 A concern about a practitioner's practise may arise from a single event or may arise as a result of a number of concerns developing a pattern.

5.6 An initial fact finding will clarify the nature of the concern and confirm the facts. See "A practical guide for responding to concerns about medical practice" NHS England March 2019 available at practical-guide-for-responding-to-concerns-about-medical-practice-v1.pdf

5.7 The nature of the concern will dictate who is best placed to gather information to provide to the case manager for their preliminary analysis. The most appropriate person will be identified by the case manager, and this may be themselves, or someone else such as the line manager, a member of Human Resources, Governance, Education or the Clinical Multidisciplinary team (this list is not exhaustive).

5.8 Consistent with the application of 'just culture' principles (Appendix 3), which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

5.9 Always consider a referral to Occupational Health for any practitioners when a concern is raised about their practice. Underlying health issues may be an underlying cause of a conduct or capability issue and should be addressed in the first instance.

5.10 Careful analysis of the severity of the concern will guide an appropriate response. Appendix 4 provides a framework for categorising the level of concern.

5.11 The response required will be assessed as

- No action required
- Supportive action / Remediation
- MHPS investigation

5.12 Where a formal MHPS investigation is being considered, PPAS will explore the issue impartially and give initial advice (see section B).

SECTION A

6. SUPPORTIVE ACTION OR REMEDIATION

6.1 This section sets out the commitment from ELHT to provide practitioners with the support and resources to meet the standards required.

6.2 When concerns are raised about a practitioner, a single coaching conversation with the line manager may be all that is required. This should be recorded on the "coaching conversation form" in appendix 5 and stored on the practitioner's personal file on WinDip, by emailing completed form to medical.staffing@elht.nhs.uk.

6.3 Remediation may be required for practitioners in the following situations:

6.3.1 Practitioners for whom the appraisal process has identified very early signs of difficulties.

6.3.2 Practitioners who have had a significant career/organisational break or other absence from practice. For example, this might have arisen through suspension/exclusion (with or without identified clinical deficiencies), a change in career path, ill-health/maternity/carers leave or other types of statutory leave, or a period working outside the NHS or outside the UK. Whether a break is 'significant' will be a matter for judgement, based on speciality, experience, job plan/content, confidence, health and work context. Absence from active practice for six months or more is a reasonable guide, consistent with current college, regulator and health department practice;

6.3.3 Practitioners whose performance has been identified as a concern through formal processes. A need for further training might have been identified by organisational clinical governance procedures including investigation and ensuring competency or disciplinary action or there might have been regulatory, NCAS, Deanery or Royal College/faculty performance assessment or review.

6.4 East Lancashire Hospitals NHS Trust is committed supporting practitioners to provide safe and effective practice. Whilst acknowledging the different underlying grounds for remediation and different issues affecting performance, once the need for remediation has been identified, an agreement must be reached on the what and how. This will include the type(s) of intervention, the plan of implementation, milestones, expected outcomes and timescales. These must be documented in a remediation agreement and uploaded to the practitioner's personal file on WinDip, by emailing completed form to medical.staffing@elht.nhs.uk.

6.5 For Doctors in Training requiring extra support, the Director of Medical Education and Training Programme Directors will oversee and manage this in collaboration with Health Education England North West, under the terms of their policies and procedures.

7 DEFINITIONS

7.1 Reskilling

Reskilling is the provision of training and education to address identified lack of knowledge or skills with application of this to the workplace enabling the practitioner to demonstrate their competence in those specific areas.

7.2 Remediation

Remediation is a broad concept varying from informal agreements to more formal supervised programmes of remediation or rehabilitation. The overall process will be agreed with a practitioner to address identified aspects of underperformance resulting in a plan for performance improvement with measurable goals.

7.2.1 Rehabilitation

The supervised period of activities for restoring a practitioner to independent practice, including overcoming or accommodating physical or mental health problems;

7.2.2 Supervised *remediation programme*

A formal programme of remediation activities with specific learning objectives and outcomes agreed with the practitioner and monitored by an identified individual on behalf of the responsible healthcare organisation. The supervised remediation programme may include a supervised clinical placement. PPAS can develop and support return to work action plans or undertake a performance assessment to develop an action plan.

8 ROLES

8.1 Practitioner

Established adult learning theory suggests that there will be more chance of success if the practitioner is able to engage with the process of remediation, develop and own an action plan, participate in the agreed interventions and provide the agreed supporting information/evidence (such as audits, reflective learning logs, certificates of completion of continuing professional developments etc.).

8.2 Line Manager

This is usually the Clinical or Divisional Director for the department in which the practitioner works who will establish a support relationship with the practitioner and undertake the following:

- Agree an action plan for addressing the concerns that have been raised, and agreed timescales;
- Oversee the reskilling or remediation of the practitioner and ensure the practitioner is making the necessary progress;

- Provide the practitioner with opportunities to comment on their remediation and on the support provided and to discuss any problems they have identified;
- Inform the Deputy Medical Director for Professional Standards of any problems that arise;
- At the end of the remediation period the line manager will undertake a final review and will review all the assessments, the portfolio of evidence of learning and ensuring that all the learning objectives of the programme have been satisfied;
- Documentation of this meeting will be shared with the Deputy Medical Director for Professional Standards and stored on the practitioner's personal file on WinDip, by emailing completed form to medical.staffing@elht.nhs.uk.

8.3 Deputy Medical Director for Professional Standards

Approve the remediation plan and is ultimately responsible for reviewing whether the objectives of the plan have been met in the timescales agreed. In the absence of the Deputy Medical Director for Professional Standards, the Executive Medical Director will undertake this role.

9 TYPES OF INTERVENTION

The remediation plan will identify the developmental needs of the practitioner and the following is a list of interventions that may be useful and is by no means exhaustive:

- Advice
- Education and training – including re-skilling
- Coaching – behavioural change
- Mentoring
- Supervision
- Placement
- Work based assessment/learning assessment
- Team based approaches
- Return from ill health or time off, e.g. phased return / return to work action plan

10 REMEDIATION OBJECTIVES AND MILESTONES

Clear objectives, milestones and timescales must be documented and will relate to the performance concerns identified. The objectives must be SMART (Specific, Measurable, Attainable, Relevant and Time bound). Appendix 6 provides ideas for action plans. Further resources for discussing concerns with practitioners can be found on OLI in the Behavioural Framework page available at https://elhtnhsuk.sharepoint.com/sites/PeopleCulture/SitePages/Behavioural-Framework.aspx

11 RECORDING AND DOCUMENTATION OF REMEDIATION

Each time the line manager or Deputy Medical Director for Professional Standards meets with the practitioner, they will complete a coaching conversation form, Appendix 5, to document the discussion and agreed actions. This will be stored on the practitioner's personal file on WinDip by emailing completed form to medical.staffing@elht.nhs.uk. The practitioner will upload evidence of the remediation for their appraisal, when requested.

12 END OF REMEDATION

The remediation plan will have specific review dates and documentation of evidence provided for the achievement of objectives. At the end of the period of remediation, the line manager or Deputy Medical Director for Professional Standards will confirm in writing the completion of the plan to the practitioner. Details of the remediation plan will be made available to future appraisers to ensure progress can be maintained and the appraisal process is informed by the plan.

13 FAILURE TO PROGRESS REMEDIATION

13.1 Where failure to progress occurs, continuing with the action plan but re-assessing objectives may be considered. A change of objectives will only be agreed where there is clear evidence of progress even though falling short of the performance standard defined in the plan. The overall time allocated to the action plan will not be extended unless there are extenuating circumstances (e.g. sickness absence).

13.2 A failure to progress in achieving the agreed objectives may result in disciplinary/capability procedures although extenuating circumstances will be considered. Disciplinary/capability procedures will be considered if, in the opinion of the Deputy Medical Director for Professional Standards or RO, in consultation with PPAS, the objectives are not likely to be met in the remaining time allocated to the action plan despite the practitioner having ample opportunity to demonstrate progress.

13.3 If the matter can progress informally with mutual agreement, PPAS may still be involved, for example, by undertaking a formal clinical performance assessment in agreement with the practitioner. If a failure to progress raises concerns in relation to patient safety or professional probity, the Deputy Medical Director for Professional Standards or the Responsible Officer may make a referral to the GMC.

13.4 If a failure to progress is related to sickness absence, it may be appropriate to defer the plan's completion date.

13.5 If the individual refuses to engage in the remediation process or does not accept the need for remediation, capability proceedings may be commenced in accordance with MHPS.

14 FUNDING OF REMEDIATION

There is strong evidence that where doctors have made some sort of personal investment in remediation, they are more motivated to follow through to a successful conclusion. It is recognised that this cannot be enforced in the absence of any national agreement. Additional resources may be available through the Division of Education, Research and Innovation or from within the Division that the practitioner works. Decisions will be made on a case-by-case basis but a fair and consistent approach will be adopted. Decisions on funding need to be fair and equitable and the investment in remediation should be proportionate to the likely outcome.

SECTION B

15 FORMAL MHPS INVESTIGATION

15.1 Reasons for proceeding to Formal MHPS Investigations include:

- Failure to reach desired outcomes through supportive actions or remediation as detailed in Section A of this policy
- Significant severity/risk identified in fact finding and/or repeated concerns

15.2 Any decision to proceed with a formal MHPS investigation will be made through discussion with PPAS. The decision will also be discussed at PSG.

15.3 Once a decision has been made to proceed with a formal investigation, the Responsible Officer or Deputy Medical Director for Professional Standards will identify the Case Manager.

16 STEP 1 – INITIAL ASSESSMENT BY THE CASE MANAGE/RESPONSIBLE OFFICER

16.1 The Case Manager will clarify what has happened and identify the seriousness of the concern in consultation with the Human Resources Director or nominated Deputy. Unless there is a need for expediency due to patient or practitioner safety risks, advice will be taken from PPAS.

16.2 Any first approach to the PPAS should be made by the Case Manager, Deputy Medical Director for Professional Standards, Executive Medical Director/Responsible Officer or Chief Executive.

16.3 The Case Manager, after discussion with the Human Resources Director or nominated deputy, should appoint an appropriately experienced person as Case Investigator and provide them with clear terms of reference for investigation. A non-executive director is appointed as “the Designated Member” to oversee the case.

17 STEP 2 – INFORMING PRACTITIONER OF INITIAL ASSESSMENT

The Case Manager must write to the practitioner to advise of the planned investigation as soon as the decision is taken. This letter must set out the name of the Case Investigator and the specific allegations that have been raised. Where more time is needed to identify an appropriate case investigator, this will be communicated to the practitioner separately (no longer than one week) and should not delay the practitioner being informed of the investigation.

18 STEP 3 – INVESTIGATION

18.1 The Case Investigator has discretion as to how they carry out an unbiased investigation. The case investigator will conduct and report the investigation in line with the standards set out by PPAS for case investigator training. Where highly complex clinical issues arise, consideration should be given to bringing in an external suitably trained individual to advise the Case Investigator. The practitioner will be given the opportunity to see appropriate correspondence relating to the case and will be made aware of who is to be interviewed. The case investigator is not required to share correspondence that could compromise the integrity of the investigation.

18.2 The Case Investigator should complete the investigation within four weeks of appointment and submit their report to the Case Manager five days after that. Where investigations take longer than 4 weeks, it is the responsibility of the Case Investigator to regularly update the practitioner under investigation of the progress of the investigation and reasons for the delay.

18.3 The Case Investigator may also be requested to produce a preliminary report within two weeks if a formal exclusion is being considered.

18.4 Case Investigators will ensure that investigations are conducted in a way not to discriminate on the grounds of any protected characteristic set out in the Equality Act 2010.

18.5 The report should give the Case Manager sufficient information to make a decision and any further recommendations.

19 REPRESENTATION

19.1 The practitioner may be accompanied throughout the processes described in this policy by a companion who may be:

- A trade union/ defence organisation representative;
- Another employee of the Trust;
- A friend, partner, or spouse.

19.2 The companion may be legally qualified, but they will not be acting in a legal capacity.

20 CONFIDENTIALITY

Case Investigators must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible and compliant with GDPR.

21 RESTRICTION OF PRACTICE

Where serious concerns arise the Case Manager should, in the first instance, urgently consider whether it is necessary to place temporary restrictions on the practitioner's practise. These restrictions can involve:

- Amending or restricting clinical duties
- Obtaining undertakings
- Excluding the practitioner from work (i.e. suspending the practitioner)

22 EXCLUSION OF WORK

22.1 Immediate Exclusion

22.1.1 An Immediate time limited exclusion may be required where a serious concern arises after:

- A critical incident when serious allegations have been made;
- There has been a breakdown in relationships between a colleague and the rest of the team;
- It becomes clear that the presence of the practitioner is likely to hinder the investigation.

22.1.2 The purpose of the exclusion is as a temporary expedient reserved for only the most exceptional cases. The purpose of exclusion must be:

- To protect the interest of patients or other staff;
- To assist the investigative process where there is a clear risk that the practitioner's presence would impede the gathering of evidence.

22.1.3 Alternative ways of managing risk to avoid exclusion should be considered, such as supervision of duties by clinical directors, restricting practise to certain clinical duties, restricting practise to administrative and research duties or sick leave (in the case of investigation of specific health problems).

22.1.4 Where the Trust is considering excluding a practitioner, the Case Manager will consult with the Trust Executive Medical Director/Deputy Medical Director, HR Director and Chief Executive. They will consider the allegation and discuss whether alternatives to exclusion can be considered. The Case Manager will also contact PPAS so that alternatives to exclusion can be considered.

22.1.5 The immediate exclusion must be for one or two purposes as identified in section 21.1.2 and can be for a maximum of two weeks. During this time a Case Investigator will be appointed to carry out a preliminary analysis of the situation. The Case Manager will explain the reasons for the immediate exclusion and the next steps.

22.2 Formal Exclusion

22.2.1 This may only take place after the Case Manager has first decided whether there is a case to answer and then considered, at a case conference, whether it is reasonable and proper to exclude.

22.2.2 Step 1 – Case Conference

22.2.2.1 The Case Conference should be attended by the Chief Executive, The Medical Director, the Case Manager and the Director of Human Resources. If there is a Case Investigator, they must produce a preliminary report as soon as possible to be available for the case conference. Also prior to the case conference, the Case Manager will consult PPAS. The Case Investigator's report should provide sufficient information for a decision to be made as to whether:

- The allegation appears unfounded;
- There is a misconduct issue;
- There is a concern about the practitioners capability;
- The complexity of the case warrants further detailed investigation before advice can be given on the way forward.

22.2.2.2 The circumstances will be considered at the case conference. Formal exclusion will only be used where there is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:

- Allegations of misconduct;
- Concerns about serious dysfunctions in the operation of a clinical service;
- Concerns about lack of capability or poor performance;
- Where the presence of the practitioner in the workplace is likely to hinder the investigation.

22.2.3 Step 2 – Considering the terms of the exclusion

22.2.3.1 The Trust will not automatically bar practitioners from Trust premises upon exclusion. The Case Manager must decide the terms of any exclusion.

22.2.3.2 Any exclusion will be on full pay and benefits and the practitioner must remain available for work during normal working hours. Applications for annual leave and study leave must be approved by the Case Manager.

22.2.3.3 The Case Manager will also ensure that the practitioner can continue to keep in contact with colleagues with regard to professional developments and take part in continuing professional development and clinical audit activities.

22.2.4 Step 3 – Informing the Practitioner

22.2.4.1 Where it is determined that a formal exclusion is necessary. The Case Manager will inform the practitioner in the presence of a witness. The Case Manager will:

- Explain the nature of the allegations/ areas of concern;
- Give reasons why exclusion is necessary and provide relevant evidence where appropriate;
- Give the practitioner the opportunity to state case and suggest alternatives;
- Inform a Designated Board Member about the exclusion.

22.2.4.2 The Case Manager will confirm the exclusion in writing as soon as is reasonably practicable. The letter will confirm:

- Date and time the exclusion took effect;
- Duration of exclusion (max 4 weeks);
- Terms of exclusion;
- What action will follow;
- That they can make representations about the exclusion to the Designated Board Member.

22.2.4.3 Where disciplinary procedures are being followed, the exclusion may be extended for further four weeks renewable periods until that procedure is completed.

22.2.5 Step 4 – Informing Other Organisations

22.2.5.1 If the practitioner may represent a risk to patients, the Trust has a duty to inform other public and private sector organisations of any restriction on practice or exclusion and provide them with a summary of the reasons for it.

22.2.5.2 Details of other employers may be available from job plans otherwise the practitioner should provide them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body. Where restrictions have been placed on practice, the practitioner should agree not to undertake any work in that area with any other employer.

22.2.5.3 Where the Case Manager believes that a practitioner about whom there are significant concerns and whom it is thought is or may be attempting to work, PPAS and NHS England will be informed to request a Health Professional Alert Notice.

22.2.6 Step 5 – Reviewing the Exclusion

22.2.6.1 The Case Manager will inform the Trust Board about the exclusion as early as possible. The Board will review all exclusions and restrictions of doctors at its monthly Board meeting.

22.2.6.2 Before the end of each exclusion period (of up to 4 weeks), the Case Manager will review the position and will:

- Decide on next steps as appropriate. Further renewal may be made for up to 4 weeks at a time;
- Submit an advisory report of outcome to the Chief Executive and the Trust Board;
- Document the review and send written notification to the practitioner on each occasion.

22.2.6.3 If a practitioner has been excluded for three periods the Case Manager will:

- Provide a report 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 is not completed a timetable for completion of the investigation;
- Update PPAS explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion at the earliest opportunity.

22.2.6.4 Exclusions should not normally exceed six months except for cases involving criminal investigation. If the exclusion has been extended over six months, the Executive Medical Director or nominated deputy, will provide a further report to the Trust Board indicating:

- The reasons for the continuing exclusion;
- The anticipated timescale for completing the process;
- Actual and anticipated costs of the exclusion.

23 INVESTIGATION OUTCOMES

23.1 Once the Case Investigator has concluded the investigation, they will send the report to the Case Manager. The Case Manager will send the report to the practitioner. The practitioner will have the opportunity to comment in writing on the factual content of the report, including any mitigation. The practitioner should return any comments to the Case Manager within 10 working days of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the Case Manager may extend the deadline.

23.2 The Case Manager will consult with the Director of Human Resources, PSG and PPAS to decide which of the following apply:

- No further action is needed;
- The concerns about the practitioners performance can be addressed with supportive action or remediation (see section A of this policy);
- There are concerns about the practitioners health that should be considered by occupational health;
- There is a case of misconduct that should be put to a conduct panel;

- There are concerns about the practitioners performance that should be further explored by PPAS;
- Restrictions on practice or exclusions from work should be considered;
- There are serious concerns that should be discussed with the GMC or GDC Employer Liaison Advisor;
- There are intractable problems and that matter should be put before a capability panel.

23.3 The case manager will write to the practitioner within 10 days of receiving their comments to communicate their decision and the next steps (if any).

24 HANDLING CONCERNS ABOUT A PRACTITIONERS HEALTH

24.1 The Trust's sickness absence policy (HR06) applies when handling concerns about a practitioner's health. The Trust will look to make reasonable adjustments where possible.

24.2 Where a practitioner is suffering from health problems, the Case Manager should consider whether the practitioner should:

- Take Sickness absence
- Be restricted from certain duties
- Be reassigned to different duties
- Consider medical suspension on the grounds of risk to patients in line with section 22 if no alternatives to exclusion are practical

24.3 Consideration will be given to whether reasonable adjustments are required under the Equality Act 2010. Adjustments to be considered will include whether appointment to an alternative role with re-training would be appropriate.

24.4 The Practitioner should be referred to the Occupational Health department and recommendations should be agreed with the practitioner and sent to the line manager.

24.5 Where issues of performance are solely due to ill-health it is unlikely that disciplinary procedures will be appropriate. However, disciplinary procedures may be implemented where the practitioner repeatedly refuses to co-operate to resolve the issue.

25 CONDUCT HEARINGS AND DISCIPLINARY MATTERS

25.1 The Trust's Disciplinary Policy (HR09) sets out standards of conduct and behaviour expected of all its employees including practitioners, breaches of which are considered to be "misconduct". HR09 identifies the informal and formal stages of managing concerns about conduct and disciplinary matters for Trust employed practitioners.

25.2 In addition to HR09, where an investigation identifies issues of professional nature or issues of professional conduct, the Case Investigator may be required to obtain appropriate independent professional advice. This advice may come from a source internally or external to the Trust. The panel at any disciplinary hearing must include a medically/dentally qualified panel member who is not currently employed by the Trust. The Case Manager will consider seeking the advice of PPAS.

25.3 Where there is an allegation of a suspected criminal act, this will be reported immediately to the Police and processes as described in MHPS will be followed.

25.4 Where there is an allegation of misconduct against a practitioner in a recognised training grade, this should be considered initially as a training issue and managed collaboratively between the PSG, supervisors and Health Education England North West programme directors and dean.

26 PROCEDURES FOR DEALING WITH ISSUES OF CAPABILITY

26.1 Concerns about the capability of a practitioner may arise from a single incident or a series of events, reports or poor clinical outcomes. See Appendix 2 for examples.

26.2 The Case Manager will also consider with the Executive Medical Director (if the Medical Director is not the Case Manager) or nominated delegate and the Director of Human Resources whether issues of capability can be dealt with through supporting action and remediation (see section A of this policy).

26.3 If local action is not practical for any reason the Case Manager will refer the matter to PPAS to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The Case Manager will inform the practitioner of the decision immediately and normally with 10 working days of receiving the practitioner's comments.

26.4 The practitioner will need to agree to the action plan before it can be implemented. There may be occasions where the PPAS conclude that performance is such that no remedial or educational action has a realistic prospect of success. In such cases it will be for the Case Manager to consider the PPAS' findings and the Case Investigator's report and conclude whether the case needs to be determined under the capability procedure by a capability panel. If the practitioner does not agree to the case being referred to the PPAS, or cannot agree an action plan, or does not engage with discussions, a panel hearing will normally be necessary.

26.5 Preparation for capability hearings. Prior to the capability hearing the following steps will be taken:

- At least 20 working days before the hearing, the Case Manager will notify the practitioner in writing of the decision to arrange a capability hearing and notify them of the date of the hearing. Notification will provide the practitioner with details of the allegations and any documents or evidence that will be put before the panel and notify the practitioner of their right to be accompanied at the hearing;
- The practitioner should be notified of the identity of the Panel members. Within 5 working days of this notification the practitioner should raise any objections to the panel members;
- At least 10 working days before the hearing, the parties must exchange final lists of witness they intend to call to the hearing. Witnesses who have made written statements at the investigation stage will not necessarily be required to attend the capability hearing. However where a witness' evidence is in dispute the Chair of the Panel can invite the witness to attend. If a witness does not attend, the panel will not attach less weight to that witness evidence.

26.5.1 Postponement requests – The Case Manager will consider any requests for a postponement and is responsible for keeping a record and ensuring that time extensions are kept to a minimum. After a reasonable period (not normally less than 30 days), the Trust retains the right to proceed with the hearing in the practitioners absence where it is reasonable to do so.

26.5.2 Panel Members – The capability hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the board for the purpose of the hearing. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust. None of the panel, as far is reasonable or practical should have had any prior involvement in the investigation.

26.5.3 In addition to the above the panel must be advised by:

- A senior member of staff from Human Resources
- A senior clinician from the same specialty as the practitioner but from a different NHS employer
- In the case of a clinical academic, a representative from the university

26.5.4 As far as reasonably practicable, no member of the panel or adviser should previously been involved in the investigation.

26.6 **The Capability Hearing.** The practitioner is entitled to be represented at the hearing in line with section 19 of this policy.

The panel and its advisers, the practitioner, their representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give evidence and to answer any questions and will then retire.

26.7 **The Decision**. The panel should retire to consider their decision and will confirm their decision in writing to the practitioner within 5 working days of the hearing. The Chairperson will notify the practitioner of the reasons for the decision and of any intention to notify the GMC or GDC or any other external body or organisation. The letter will also confirm the practitioner's right to appeal.

26.7.1 The panel can make a wide range of decisions and may make comments on issues not related to clinical competence where necessary. The following is a non-exhaustive list of potential decisions that the panel could make:

- No action required;
- Agreement that there must be improvement in clinical performance within a specified timescale and a written statement as to what is required and how this may be achieved (stays on employee's record for 6 months);
- Written warning that there must be an improvement in clinical performance within a specified timescale with a statement of what is required and how this can be achieved (stays on employee's record for 1 year);
- A final written warning that there must be improved clinical performance within a specified timescale and how this must be achieved (stays on employee's record for 1 year);
- Termination of the practitioner's employment.

26.7.2 The practitioner may appeal within 25 working days of receiving the original decision by sending an appeal statement to the Director of Human Resources.

26.8 **Appeal.** The appeal will be a review of the original hearing rather than a full re-hearing although the appeal panel will be able to hear new evidence. The appeal panel will consider whether the original hearing followed a fair and thorough investigation, whether there was sufficient evidence from the investigation to justify the conclusions reached and whether the conclusion reached was fair in the circumstances.

26.8.1 The appeal panel should consist of:

- An independent person designated as the Chairperson and trained in the legal aspects of appeals from the approved pool appointed by the NHS Appointments Commission;

- The Chairperson of the Trust Board or another Non-Executive Director who has been trained to sit on appeals panels. This will not be the Designated Board Member;
- A medically or dentally qualified individual not employed by the Trust.

26.8.2 The panel should obtain specialist advice from:

- A consultant in the same specialty as the practitioner but not employed by the Trust;
- A Senior Human Resources specialist.

26.8.3 Prior to the appeal hearing the following steps will be taken:

- An appeal hearing will be convened within 25 days of the appeal being lodged;
- At least 10 working days before the appeal hearing the appeal panel may notify the appellant (or their representative) and the management representative if it considers it necessary to hear evidence from any witness. The appellant (or their representative) and the management representative will provide written statements from any relevant witnesses to all parties at the same time. Both parties should confirm any additional evidence on which they intend to reply.

26.8.4 At the appeal hearing the practitioner can be represented as set out in section 19. The panel has the right to consider new evidence but should consider adjournment in such circumstances in order to ensure the parties have time to prepare.

26.8.5 The appeal panel can confirm the decision that was made by the original capability panel, amend the decision or order that the case be re-heard. The chairperson will inform the practitioner of the decision within 5 working days of the hearing and provide reasons for this. The decision of the appeal panel is finding and binding.

26.9 **Conclusion of the Process.** At the conclusion of the process a record will be kept on the practitioners file on WinDip by sending outcome letter to medical.staffing@elht.nhs.uk. This will contain a statement of the capability issues, the action taken and the reasons for this. These records will be kept confidentially and in accordance with Data Protection Act 2018 and only released when a legitimate request is received.

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

27 MONITORING AND REVIEW

This policy was approved at JLNC and will be reviewed every three years or sooner if necessary. All proposed changes will be submitted to JLNC for negotiation. The Terms of Reference for the PSG will be reviewed annually by the Joint Local Negotiating Committee.

28 MONITORING MECHANISM

Measuring and monitoring compliance with the effective implementation of this procedural document is best practice and a key strand of its successful delivery. Hence, the authors of this procedural document have clearly set out how compliance with its appropriate implementation will be measured or monitored. This also includes the timescale, tools/methodology and frequency as well as the responsible committee/group for monitoring its compliance and gaining assurance.

Aspect of compliance being measured or monitored.	Individual responsible for the monitoring	Tool and method of monitoring	Frequency of monitoring	Responsible Group or Committee for monitoring
Cases discussed at Professional Standards Group	Deputy Medical Director for Professional Standards	Prospective audit	2 yearly (Aug)	PSG Trust board
Regular review of restrictions of practice	Deputy Medical Director for Professional Standards Responsible Officer NED	Monthly PSG meeting	Monthly	Trust board
MHPS Investigations	Case manager	Monthly PSG	Monthly	Trust board

APPENDIX 1 – DIDO HARDING RECOMMENDATIONS

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

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

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

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

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

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

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

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

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

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

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

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

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

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

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

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

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

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

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

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

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

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

1. Adhering to best practice

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

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

2. Applying a rigorous decision-making methodology

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

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

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

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

4. Assigning sufficient resources

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

5. Decisions relating to the implementation of suspensions/exclusions

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

6. Safeguarding people's health and wellbeing

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

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

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

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

APPENDIX 2 – ISSUES AFFECTING A PRACTITIONER'S PERFORMANCE

Concerns affecting a practitioner's performance can be identified from a number of different sources, which can include:

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff
- Review of performance against job plans, annual appraisal documentation and/or revalidation
- Monitoring of data on performance and quality of care
- Mortality reviews
- Clinical governance, clinical audit and other quality improvement activities
- Complaints about care by patients or relatives of patients
- Information from the regulatory bodies
- Litigation following allegations of negligence
- Information from the police or coroner
- Court judgements
- Patient surveys

It is recognised that a practitioner's performance can be affected by a complex range of issues. All of the issues listed below can affect performance, but not all will be amenable to remediation:

Skills and knowledge deficit – for example	• A lack of training and education • Lack of engagement with continuing professional development and/or maintenance of performance • A practitioner trying to take on clinical work that is beyond their current level of skill and experience
Behaviours and attitudes – for example	• Loss of motivation, interest or commitment to medicine or the organisation through being stressed, bored, bullied • Being over-motivated, unable to say no, overly anxious to please • Poor communication skills • Poor timekeeping • Poor leadership/team working skills
Context of work – for example	• Team dysfunction • Poor managerial relationships • Poor working conditions • Poor or absent systems and processes
Environment – for example	• Marriage/partnership break up • Financial concerns

Health concerns including capacity and/or capability – for example	• Physical conditions including drug and alcohol misuse • Psychological conditions including stress and depression • Cognitive impairment/deterioration
Probity – for example	• Boundary issues • Altering clinical records • Conflicts of interest
Criminal behaviour – for example	• Falsifying expenses • Theft • Assault
Capability – for example	• Out of date clinical practice • Inappropriate clinical practice arising from lack of knowledge or skills that put patients at risk • Incompetent clinical practice • Inability to communicate effectively • Inappropriate delegation of clinical responsibility • Inadequate supervision of delegated clinical tasks • Ineffective clinical team working skills

APPENDIX 3 – A JUST CULTURE GUIDE

A just culture guide

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

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

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

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

Please note:

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

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

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

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

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

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

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

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

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

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

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

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

if **Yes to all** go to next question - **Q4. substitution test**

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

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

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

If Yes to any

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

END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

Yes

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

END HERE

if **No**

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

END HERE

improvement.nhs.uk

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

Supported by:

Academy of Medical Royal Colleges · avma · BMA · CareQuality Commission · GMB · General Medical Council · National Guardian Freedom to Speak Up · NMC Nursing & Midwifery Council · Royal College of Nursing · Royal Pharmaceutical Society · UNISON Health Care · Unite the Union

NHS England and NHS Improvement

APPENDIX 4 – CATEGORISATION FRAMEWORK

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

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

Section B – Likelihood

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

Section C – Risk Score

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

Section D – Less common consequences:

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

APPENDIX 5 – COACHING CONVERSATION FORM

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Record of Supportive Coaching Conversation	
Name	
Department	
Date of Discussion	
Date	
Final Review Date (3-6 Months from date of conversation)	

1. Reason for Feedback:
7. Observation/Examples:
8. Opportunity to discuss if there is any additional Support/Training required that will assist the colleague?
9. Discuss Agreed Actions/Next Steps/Review Date:
10. Feedback for the Manager/Additional Notes
11. Reflection from colleague (where appropriate)

Colleagues Signature	
Managers Signature	

*Manager to provide colleague a signed copy of this form

*This form can be referenced for any repeat in concerns up until 12 months following the discussion or beyond this if there are clear repeated patterns of concern

Supportive Coaching Conversation Guidance Notes

A supportive conversation can take place when you have an informal 1 to 1 with a colleague to discuss any observations that require further discussion. In cases where there may be some concerns, it is important that the colleague clearly understands why, and what the expected standards of conduct or performance are required in their role. This should include a conversation about what the implications maybe to the colleague if improvements are not made to their conduct/performance. Also it gives us an opportunity to identify if there are any improvements that the manager can consider e.g. improved induction, communication, training, team work, recognition.

Q1. Reasons for feedback

Here the Manager would explain to the colleagues that some concerns/issues have been identified or brought to the manager's attention that they would like to discuss. Here the colleague would have an opportunity to provide an explanation surrounding the issue, before a decision on what the agreed actions will be.

Q2. Examples

Here the manager would share with the colleague some examples of the issues or concerns that have been raised. Examples could include a communication or observation from the Manager or feedback from colleagues/patients/customers on the colleagues conduct or performance.

Q3. Opportunity to discuss any support

As the manager discusses the issues and any information that the colleague wishes to raise with them regarding them, this is where you would agree on any actions and support that is necessary to achieve an improvement going forward, such as a need for training etc. Anything discussed here may also be appropriate to include in the colleague's appraisal.

Q4. (If applicable) Discuss Agreed Actions/Next Steps/Review Date

Here the manager would explain what is expected of the employee in the future. This must include timescales and review periods as necessary. The next steps should include informing the colleague of what the implications are for them if the improvements are not made e.g. Providing the improvements are made confirm there is no further action required at this time OR (Depending upon the seriousness) if a similar matter arises in the future this may need to be considered formally in line with the most appropriate Trust policy. Examples may include; Performance Management/Discipline.

Q5. Feedback for the Manager/Additional Notes

The manager should use this opportunity to ask the colleague if there is anything else that they would like to discuss, or if they would like to provide feedback to their manager. Additional notes can also be captured in this section. If you need any help completing this form or require any further advice, please contact your divisional HR team.

Q6. Colleague Reflection

When appropriate, ask the colleague to reflect on their actions/issues raised and given them the opportunity to add in this section.

APPENDIX 6 – SUGGESTIONS FOR ACTION PLAN

Occupational Health Referral

An Occupational Health referral should be considered for all practitioners requiring additional support.

- Phased return
- Return to work action plan

Behaviours

- Reflection
- 360 feedback from colleagues and/or patients
- Signposting to appropriate reading (books, journals, websites)
- Attendance at courses e.g. NW Leadership Academy
- Mediation
- Mentoring
- Coaching

Performance

- Audit of outcomes
- Audit of utilisation
- Review of IR1s
- Review of complaints
- Dr Foster data
- Work based assessment/learning assessment
- Reading / CPD
- Observing others
- Being observed
- Royal College courses
- Conferences

APPENDIX 7 – EQUALITY IMPACT ASSESSMENT

Department/Function	Human Resources			
Lead Assessor	Liam Reeve			
What is being assessed?	Responding to concerns about clinical performance			
Date of assessment	January 2024			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	**Equality of Access to Health Group**	☐	**Staff Side Colleagues**	☒
	Service Users	☒	**Staff Inclusion Network/s**	☐
	Personal Fair Diverse Champions	☐	**Other (Inc. external orgs)**	☐
	Please give details: Policy has gone through all relevant internal committees for approval and been seen by Consultants.			

1) What is the impact on the following equality groups?		
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact (Positive / Negative / Neutral)**	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	None

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.

- This should include where it has been identified that further work will be undertaken to further explore
- the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**
n/a		