Public Health England

Protecting and improving the nation's health

PHE Advisory Board

Date of meeting	Wednesday 21 November 2018
Sponsor	Deborah McKenzie, Chief People Officer
Presenter	Professor Richard Parish and Deborah McKenzie
Title of paper	Independent report commissioned by PHE from Professor Parish following a recommendation by the Employment Tribunal and PHE Management Response

1. PHE was established as the new national public health agency in April 2013, bringing together over 5,000 staff from 70 plus organisations. From the start, there has been a consistent focus not just on the importance of what we do, but on how we do it, making people able to do their best work and feel respected by the organisation. Our annual staff survey scores, the most recent of which were published last week, have strengthened year-on-year and assist in identifying areas for further focus and attention by leaders and managers at all levels of the organisation.

2. PHE has in place a range of HR-related and other procedures through which staff can raise concerns about their employment or issues in the workplace, for example, through the grievance process, or the raising concerns (including whistleblowing) policy. Increasingly, there is a focus on early conciliation and mediation of grievances, with the majority being satisfactorily resolved without recourse to the more formal stages. Only two cases have progressed beyond PHE's internal processes through to a full hearing at the Employment Tribunal; one being dismissed and one being upheld, which is the case in question here. We are not in any way complacent and our wider work on ensuring a fair and inclusive workplace is set out in the management response to Professor Parish's report.

3. The case in question concerned a claim by Dr Femi Oshin, a public health consultant who was formerly employed by first the Health Protection Agency and subsequently in PHE's South West Centre, and who left the organisation in the summer of 2015. The case was subsequently heard by the Exeter Employment Tribunal in the autumn of 2016 and the subsequent remedies hearing in April 2017 and is summarised in both Professor Parish's report and the opinion from leading Counsel. In short, the Tribunal found that there had been race discrimination and victimisation with respect to the handling of an investigation under Maintaining High Professional Standards, which applies to PHE medical and dental staff, and the way in which the recommendation for professional revalidation with the GMC was handled. PHE accepted the findings of the Tribunal, paying the compensation ordered promptly, and electing to focus efforts on reviewing systems and processes to minimise the chance of any recurrence.

4. At the remedy hearing in April 2017, it was therefore agreed that the Tribunal would recommend to PHE that it should commission a review by Professor Parish, with a terms of reference to be set by him, to facilitate this process. This has taken longer than he would have liked due to serious illness at the turn of the year. We are most grateful to Professor Parish for completing the report on his road to recovery and for the care and diligence he has clearly spent on it. A copy is attached at Annexe A, which includes the addendum from Capsticks LLP.

5. During his tenure as Acting Chair of the Advisory Board, which concluded on Dame Julia Goodfellow's appointment as Permanent Chair in September, Sir Derek Myers asked for assurance that Professor Parish's report and the addendum had satisfactorily fulfilled the Tribunal's recommendation and reached sound conclusions, as well as to determine whether there were any further steps which PHE should consider in light of the Tribunal's judgments and Professor Parish's report. Leading Counsel was instructed (Ben Cooper QC of Old Square Chambers), and a copy of his opinion is provided at Annexe B. In summary, he has concluded that:

    - Professor Parish's report has satisfactorily addressed the Tribunal's recommendation in its terms of reference, process and recommendations;

    - Professor Parish's findings and recommendations appear reasonable based on the information available to me and consistent with the terms of the enquiry;

    - for the purpose of implementing Professor Parish's recommendations, he has noted some supplementary suggestions or caveats in relation to particular recommendations as set out in his opinion; and

    - aside from those matters, there are not in my view any outstanding issues to be addressed in order to fulfil the Tribunal's recommendation.

6. We have carefully considered the report and prepared a management response, which is set out at Annexe C, including the action that has already been taken. We are committed to delivering this in full, with progress to be reported regularly to the PHE Management Committee, the executive decision making body in PHE. At the request of Sir Derek Myers, we have also provided a range of supporting HR-related data (Annexe D).

7. Dr Oshin has been invited to join the discussion at Wednesday's Advisory Board meeting and has received a full copy of this paper in advance, as have the Chair, Deputy Chair and Secretary of PHE Staff Side and the Chair of the PHE Local Negotiating Committee. Dr Oshin has confirmed his attendance, and the Chair will invite him to contribute to the discussion at Wednesday's meeting.

Deborah McKenzie
Chief People Officer

16 November 2018

ANNEXE A

IN STRICTEST CONFIDENCE

ENQUIRY FOLLOWING THE EMPLOYMENT TRIBUNAL

involving

Dr. B. Oshin and Public Health England

1.0 INTRODUCTION

This report results from an Employment Tribunal initiated by Dr. B. Oshin against Public Health England and heard in October 2016, with a remedy hearing in April 2017 in Exeter. The Tribunal was chaired by Employment Judge Housego. The Tribunal found in favour of Dr. Oshin and concluded that:

- The Claimant (Dr. Oshin) was constructively (and) unfairly dismissed by the Respondent (PHE)
- There was no contributory conduct by the Claimant
- The Respondent victimised the Claimant for raising a claim of race discrimination and in respect of an Employment Tribunal claim
- The Claimant was subject to direct race discrimination by the Respondent.

As part of the Remedy Hearing, the Tribunal concluded that there should be a review with recommendations to Public Health England.

"The Tribunal recommends that the Respondent commissions a report from Professor Richard Parish, who, having been given a copy of the liability and remedy decisions of this Tribunal, is asked to set his own terms of reference for an enquiry which he is asked to chair, and he is to appoint those he considers best to assist him as a tribunal of enquiry, and that tribunal is to make recommendations arising from that enquiry."

My name was discussed with both parties to the Tribunal proceedings and there was agreement that I would be an appropriate individual to conduct the Review/Enquiry. I have done so in an independent capacity, not as a PHE Advisory Board Member, although my membership of the Board was disclosed fully and understood by all concerned.

I have made a number of recommendations to Public Health England's management, which are set out in section 4. The focus is on ensuring that systems and processes with respect to investigations into alleged misconduct by PHE medical staff are fair, proportionate, and non-discriminatory.

My conclusions and recommendations follow.

2.0 PROCESS FOR CONDUCTING THE REVIEW

In setting my own Terms of Reference, I entered into discussions with both parties to see if an agreement about the scope and purpose could be reached.

Dr Oshin throughout has been strongly of the view that my Review should focus on 'institutional racism'. I took the view from both the Judgement and the Remedy Hearing that it would be more appropriate to focus on how best to minimise the chances of such a situation occurring again and the arrangements necessary to guarantee the fair and non-discriminatory treatment of all PHE staff.

The Tribunal did not use the term 'institutional racism', although it did conclude that there had been 'unconscious race discrimination' on PHE's part and that the investigation into Dr. Oshin's conduct had fallen *'between the Scylla and Charybdis of utter incompetence and subconscious discrimination'*. The Tribunal also criticised PHE management for what it described as *'group think'* and *'institutional discrimination'.*

The Terms of Reference were determined as follows:

1. To consider whether the arrangements in place governing investigations under the Maintaining High Professional Standards (MHPS and MPS) procedures are equitable and fair to doctors from all backgrounds.
2. To review the arrangements for an individual being investigated under MPS to ensure that she or he can raise concerns and /or issues about the proposed Terms of Reference.
3. To consider whether there are adequate processes in place to ensure that the individual being investigated can make representations on the report prepared by the Case Investigator before a decision is made by the Case Manager and/or Responsible Officer.
4. To determine the adequacy of the arrangements for ensuring that all staff involved in the process are trained appropriately, act objectively and remain up to date.
5. To determine whether there are robust, transparent and fair policies and procedures in place in reaching decisions about medical revalidation, including transparency of communication with the GMC as the professional regulatory body.
6. To clarify the arrangements for appeal should a recommendation regarding medical revalidation be in dispute.
7. To review the arrangements for appealing a stage one decision in the grievance process in circumstances where an employee is about to leave or has actually left the organisation.
8. To review this case in the light of Dr Oshin's experience and the Tribunal's findings and make recommendations for organisational improvement.
9. To consider the governance and accountability arrangements regarding the above and, if necessary, to recommend how these should be strengthened.

In conducting my review, I have sought to collect background information from a variety of individuals within PHE. Given the sensitivities of the case and my request that staff speak frankly, I conducted these interviews on a one-to-one confidential basis. They were extremely helpful in enabling me to understand the nature of any failings and in guiding me towards relevant policies and procedures. These interviews also helped me identify various communication issues for further investigation. In my view, a Panel approach would not have been successful in getting 'under the skin' of the events leading to the Tribunal case, given the sensitivities involved. I am certain that staff would have felt inhibited in speaking frankly.

In short, my Review has been based on:

a) Confidential interviews where possible;
b) A documentary analysis of relevant policies, procedures, roles and responsibilities, where available, supplemented by a review by an independent law firm which had not previously been involved in the case (see separate report)
c) The Tribunal Judgement and Remedies;
d) Communications with Dr. Oshin, including a meeting in Edinburgh.

My draft Report and its conclusions were then tested for accuracy, relevance and legal compliance through a variety of routes, including a small independent reference panel with knowledge of PHE. This Panel helped to identify any further work necessary and highlighted issues for clarification. This Panel comprised:

- Martin Hindle, an experienced NHS and private sector Chair and Chief Executive with extensive overseas experience, who holds an MSc in Industrial Administration. He is the Independent Member of PHE's Audit and Risk Committee.
- Poppy Jaman, OBE, Chief Executive of City Mental Health Alliance, Former Chief Executive of Mental Health First Aid England and an independently appointed member of PHE's Advisory Board. Ms. Jaman was also until recently a Member of the Board for the NHS Workforce Race Equality Standard.

The Draft Report was also tested to check that it had relevance and practical application; in effect to ensure that it would 'make a genuine difference'.

As a consequence of these processes, I have drawn a number of observations and conclusions, resulting in various recommendations.

I accepted Dr. Oshin's request that the Report should be submitted to PHE's Advisory Board to allow the Board to reflect on the recommendations and suggest amendments, bringing to bear their broad experience, not just of PHE but also other organisations. Clearly, this also contributes to effective governance oversight in implementing the recommendations.

3.0 SPECIFIC OBSERVATIONS AND CONCLUSIONS

My observations, listed below, should be read in conjunction with the timeline of events (see Appendix 1).

a) It seems clear that Dr. Oshin was not aware of some key information held on his personal employment file (about an incident in 2010) which transferred to PHE from the Health Protection Agency (HPA) in April 2013. Dr. Oshin believed he had been exonerated and assumed that the incident was now 'dead and buried'. However, the 2010 incident, although resolved, continued to form part of this file. It appears that Dr. Oshin had not seen the report of the 2010 investigation. Even though the investigation had been dropped, the file note of that investigation remained.

b) The Managing Professional Standards (MPS) investigation in 2014 conflated issues with very different origins, namely management concerns about working practices and Dr. Oshin's request for clarity about the 'bullying' allegations against him.

c) In rightly ensuring that fairness, equity and appropriate professional behaviour are overriding considerations in any work environment, it is important when something goes wrong that the management response is proportionate to the dispute and avoids 'overkill'.

d) Dr. Oshin's Annual Appraisals appear to have been entirely satisfactory in all aspects of his work with no criticisms and some points of commendation. Any concerns about, or alleged criticisms of, Dr. Oshin do not appear to have been raised during the appraisal process.

e) PHE managers concluded that the 2013 allegations of bullying made against Dr. Oshin were not serious enough to warrant an investigation. Nevertheless, Dr. Oshin himself asked for an investigation to be conducted under the *Bullying and Harassment Policy.* It was Dr. Oshin who requested an investigation in order to clear his name, not his employer. This eventually turned into an investigation of Dr. Oshin himself. PHE chose to use MPS for a number of perfectly understandable reasons, but this may have had the unintended consequence of escalating the situation, despite being designed to safeguard the practitioner through what should have been potentially a more rigorous process.

f) The National Clinical Assessment Service (NCAS) was consulted about the investigation process and PHE was advised clearly to follow the MPS/MHPS route. However, information provided to NCAS had conflated both the alleged bullying (investigation requested by Dr Oshin) and the management concerns about working practices (PHE initiated). This could have potentially distorted the advice from NCAS.

g) The MPS investigation included the allegations against Dr.Oshin of bullying from the HPA days, which had in fact already been reviewed and concluded. This appears to breach the principle of Double Jeopardy in the absence of any new evidence.

h) In conducting this Review, I have become aware of the very considerable number of policies, processes and procedures concerning discrimination, disciplinary matters, grievances, bullying and harassment, conduct, investigations, and all the associated issues. Few people in the organisation have a full overview of how all

the policies and processes interconnect, despite the training available to staff, some of which is compulsory.

i) The External Independent Person (EIP) was conspicuous by his/her absence, despite the key role this appointment has in ensuring the fairness of the investigation. This is perhaps even more important where there are potential issues of discrimination. The value and importance of this role cannot be overstated.

j) The Tribunal commented on the confusion with respect to the MPS Terms of Reference (ToR). The investigation was carried under initial ToR which were noticeably different from those confirmed by the Case Manager, thereby distorting its focus.

k) The Case Investigator's (CI's) Draft Report demonstrated inaccuracies, inconsistencies and deviated from the Case Manager's ToR. It also addressed issues already determined and concluded by previous investigations or resolved through normal management processes. It was unclear whether the CI was investigating conduct, capability or a combination of these and other issues. Moreover, the investigation relied at times on hearsay or unsubstantiated information. The Tribunal was highly critical of the MPS investigation. This is despite the requirement under MPS for all managers and directors who are undertaking investigations or sitting on Disciplinary, Capability or Appeals Panels to have undergone formal equal opportunities training prior to undertaking such duties. Case managers, Case Investigators and Panel Members were trained by NCAS in the operation of disciplinary and capability procedures.

l) The CI's Report is used to inform the Case Manager's (CM's) decision. It is part of the role of the CM to challenge the evidence and any assumptions prior to reaching her or his decision.

m) The Draft CI's Report was made available to Dr. Oshin, who responded with a 30 page critique, including concerns about flaws in the investigation process.

n) On the issue of contact with the local MP, the guidance from HR stated that this may be a breach of the Civil Service Code as the information was regarded as being privileged and only available to PHE staff. As it happens, the closure of the St. Austell Office had already recently been put into the public domain. The email from HR was presented as 'advice', not a management instruction, although there is a clear expectation that such advice should normally be followed. Dr. Oshin states that his motivation in meeting the MP was, in his view, a matter of public safety or interest, which the Tribunal accepted. In evidence to the Tribunal, PHE acknowledged that the organisation's policies specifically exempted doctors from matters of confidentiality where public safety is involved. The Tribunal concluded that *'his actions were entirely within the policies of the Respondent (PHE) and the law on public interest disclosure*'.

o) On the matter of revalidation, PHE was required to bring any new issues to the attention of the GMC. It is not a matter of discretion. PHE fulfilled its obligations in this regard, although this could have been interpreted as a discretionary decision potentially prejudicial to Dr. Oshin's career. All revalidation processes are governed strictly by the Responsible Officer (RO) regulations. The GMC must be consulted before any decisions are taken about revalidation when new information comes to the attention of the RO. PHE had initially recommended

revalidation and the notice to GMC merely put Dr. Oshin back in the queue. It is important to note that he was not deferred! The correct terminology for the employer to use in these circumstances is that an 'incorrect' revalidation submission had been made and this is what PHE did. From Dr. Oshin's perspective, however, this is an issue which should never have arisen and therefore should not have been pertinent to his revalidation. It is clear to me that the obligations of the employer when faced with such situations are often not well understood by those outside of the Office of the Responsible Officer.

p) The legal and regulatory issues surrounding medical registration, conduct, obligations, and revalidation are complex and detailed. The PHE HR Department (now People Directorate) appears to work well with the Office of the Responsible Officer, but the mechanisms for guaranteeing access to specialised expertise about revalidation must clearly be kept under review.

q) The Case Manager (CM) for Dr. Oshin's MPS investigation was coincidently the same individual as the Responsible Officer (RO). This can lead to the perception of a conflict or overlap of interest in the circumstances of Dr. Oshin's case.

r) The Grievance of alleged Race Discrimination within PHE was not upheld overall, although it did find in Dr. Oshin's favour on two counts. Dr Oshin lodged an Appeal against the grievance outcome, which was heard by another very senior member of medical staff not previously connected with the earlier issues. This Appeal happened after Dr. Oshin had left the organisation. It is not clear whether the focus of the Appeal was primarily on the substance of Dr. Oshin's concerns or on the process adopted by the original Grievance hearing. It was not upheld on the grounds that there was no evidence to support the Appeal.

s) There appears to be no specific provision for grievances to be dealt with once PHE employment has ended. Given that there would be no other avenue to bring the Grievance process to a conclusion and that PHE was the employer at the time, this could prevent the individual who raised the grievance from satisfactorily gaining closure.

4.0 RECOMMENDATIONS

Recommendation 1 – Early intervention to resolve issues.

The principle of proportionality should apply in dealing with a workplace conflict between staff. Any form of formal investigation has the potential to escalate a dispute. Mediation should always be considered as a possible first course of action in attempting to resolve disputes and the mechanisms for mediation should be clear and unambiguous.

Recommendation 2 – Training of those involved in case work

The effectiveness of the grievance training should be reviewed by PHE in consultation with NCAS to ensure that Case Investigators are fully competent to undertake the investigation in hand.

Recommendation 3 – Ensuring policies and procedures are easily understood.

PHE should conduct a review as to which policies and procedures are appropriate for any given situation. Such a review should be conducted in consultation with NCAS, the GMC, and Staff Side Representatives.

The People Directorate (Human Resources Department) should, in discussion with the Office of the Responsible Officer (ORO), produce an overview of PHE's policies. This should include a flow chart of how they interrelate and interconnect in practice; in effect enabling managers and staff to navigate more easily through the various systems and procedures.

Recommendation 4 – conduct of investigations

Separate issues should be investigated independently unless there is an overriding reason for not doing so. Where there is a justifiable interrelationship, this should be made explicit as part of the Terms of Reference.

The role of the External Independent Person should be enhanced and responsibilities clarified, including the process for appointment. Their training should be prescribed. Any relationship to the organisation, senior staff, or the person under investigation should be disclosed. In exercising independent oversight of the investigation, they should have access to the PHE Chair, Chief Executive and Responsible Office, if they have any misgivings.

The individual under investigation should have the right to comment on the Terms of Reference to both the Case Manager and the External Independent Person (EIP). Such comments and any concerns should be recorded formally in the Case Manager's Final Report. The EIP should have the authority to resolve any differences of view.

The ToR used must be those determined by the Case Manager (not the Case Investigator), under the scrutiny of the EIP, both of whom should formally sign-off the ToR. There must be absolute clarity about whether the focus of an investigation is on conduct, capability, a combination of both, or some other concern. The EIP should address any lack of clarity prior

to the start of the investigation. Unsubstantiated or uncorroborated hearsay should not constitute evidence and should be disallowed.

The Case Manager should in future check with the External Independent Person that she/he is comfortable with the process prior to reaching her/his decision. The EIP should pay particular attention to issues of potential discrimination or bias.

The Case Manager's Final report should address explicitly any concerns raised by the staff member under investigation following receipt of the Draft Report from the Case Investigator. Any complaint or suggestion of discrimination on any grounds covered by the 2010 Equalities legislation should be addressed explicitly in the final report of any Grievance Hearing in addition to any more general issues of potentially unfair or inequitable treatment.

Recommendation 5: use of documents relating to prior investigations.

Where an investigation, formal or informal, has been conducted involving a member of staff, there should be full disclosure about the retention of documentation and any potential future reference to it, whilst observing confidentiality.

Any file note referring to a past investigation should state explicitly if the member of staff had been cleared of any culpability or blame. It should be shared with the staff member, who should also be able to comment.

Earlier investigations resulting in a staff member being cleared of culpability or blame should not be used in subsequent investigations except where there is an overriding reason for so doing. Where included, the Case Investigator should justify its inclusion. The Case Manager, in consultation with the External Independent Person, should determine its relevance to the current investigation. The Member of Staff should be given an opportunity to contest its inclusion.

Where earlier reports are deemed relevant to a current investigation, they should be used in their entirety and only redacted to protect essential confidential information. Any potentially discriminatory references should not be redacted under any circumstances.

Any investigation should consider the value of including Annual Appraisal reports in reaching its conclusions. In similar vein, the Case Manager should look at how Annual Appraisals might be utilised in implementing the outcomes of a case investigation.

PHE should continue a grievance process through to its conclusion after a member of staff has left employment, providing the grievance was lodged prior to that departure.

Recommendation 6 – quality assurance

The People Directorate (HR Department), and indeed the Courts themselves, must have ready access to specialised expertise on matters of medical registration and revalidation to ensure a full understanding of and compliance with the requisite statutes. The rigour with which annual medical appraisals are conducted should be reviewed to determine their effectiveness and the process strengthened, if deemed necessary.

PHE should consider whether it is prudent to embody the responsibilities of Case Manager and Responsible Officer in the same individual given that an MPS investigation has implications for medical registration or revalidation.

The arrangements for Appeals should be reviewed and a checklist provided by the People Directorate to the Chair of the Appeals Panel to ensure full compliance with PHE policies. This should include a full briefing to the Chair and Terms of Reference for the Appeal. A Grievance Appeal should always comprise a minimum of three people, including a Staff Side representative and an independent person. The outcome should not be based on papers alone and the appellant should be given the opportunity to make their own case at a Grievance Hearing.

Upon receipt of this report, the People Directorate should produce a report for the Chief Executive and the Advisory Board describing how its anti-discrimination measures will be monitored. A report on impact should be presented to the Board every six months.

5.0 GENERAL CONCLUSIONS

5.1. One is left with the overriding conclusion that from the start in 2010 until Dr. Oshin left PHE at the end of July 2015 this rather sorry tale of events developed a momentum of its own. In my view, admittedly with the benefit of hindsight, there were numerous opportunities to review the mix of issues which ended up at the Employment Tribunal and in a way that would have de-escalated the situation. The altercations with nursing staff on two occasions were not considered serious enough for further investigation at the time and yet remerged as part of the 'serious concerns' cited at later stages. The management issues concerning attendance at the ARC should have been resolved at the local level and it is disappointing that they were so easily escalated to higher levels.

5.2 The misuse of language and terminology further complicated the journey from genesis to Tribunal. The term 'serious concerns' can trigger a course of action which is not justified by the events themselves. This is particularly pertinent when issues have already been determined as not warranting further investigation. The PHE document '*Maintaining Professional Standards in PHE for Medical and Dental Practitioners*' (April 2013) highlights the need for common sense and of course this includes the use of language appropriate to the situation. Paragraph 1.3 of this document states *'As a general principle, it is expected that the immediate line manager of the practitioner in consultation with appropriate management, for example a Regional Director (where the Regional Director is not directly involved) will deal with issues of minor misconduct or performance without resort to the Medical Director'. 'In such circumstances it may or may not be appropriate for the Medical Director to be informed of the outcome. If the matter is reported to the Medical Director then he or she has the discretion to informally investigate the issue that may include the setting up of a small panel…….The above approach can be utilised for the full range of issues including those of potential harassment and bullying.'* Again, with hindsight, there do appear to have

been various opportunities to resolve these issues much more rapidly and without recourse to more formal procedures. This would have been even more appropriate given Dr. Oshin's consistently good annual appraisals.

5.3 Clearly separate issues ended up becoming conflated. It was Dr. Oshin who requested an investigation to 'clear his name' following the bullying allegations, which had been seen by PHE managers as not being serious enough to warrant any further investigation. PHE nevertheless agreed to an investigation under MPS, not the 'Bullying and Harassment Policy' as requested, which then focussed on Dr. Oshin's own conduct and 'other management concerns' rather than the matters raised by Dr. Oshin. Had Dr. Oshin not requested an investigation it seems entirely possible that there would have been no investigation at all. This had been the conclusion previously when 'bullying' allegations had been made. Indeed, one of the key instigators of the allegations had a 'track record' of such claims against colleagues, including against Dr. Oshin's own Line Manager. Dr. Oshin ended up with an entirely different investigation to the one he had asked for, which was inappropriate in the context of his request.

5.4 In addition, it is not clear to me why a Centre Director drew up the Terms of Reference for the MPS investigation and determined who the witnesses should be, rather than the Case Manager. In so doing, this resurrected allegations of bullying, which had previously been 'put to bed'.

5.5 Given the number of players, levels, departments and policies, it is perhaps not surprising that there were communication misunderstandings. The organisation was also going through a period of major transition, merging over 120 bodies into a single entity, namely PHE. Communications were complicated and distributed. This complexity worked against the interests of Dr. Oshin as well as at times confusing the processes from a PHE management perspective. Dr Oshin attempted to seek clarification on a number of occasions, but did not always receive an adequate response.

5.6 The Tribunal reached a conclusion of 'Group Think' in the way PHE managed the different stages of performance, allegations of bullying, investigation, grievance and appeal. This contributed to the Tribunal's determination of race discrimination. Although I did not find evidence of conscious collaboration at the different stages from 2010 to 2015, it does appear that there was too ready an acceptance of hearsay, anecdotal information and assumptions as if they constituted evidence or fact. This may well have distorted the conclusions drawn at every stage, each one potentially impacting upon decisions at the next stage.

5.7 The suggestion to Dr Oshin that he should apply for Voluntary Exit highlighted his concern of 'race discrimination'. In the words of the Tribunal, he felt that *'there was a wish of those in the organisation to rid themselves of him'*. This formed the basis of his grievance lodged in January 2015 and the appeal later in the year. It is unclear to me whether there was sufficient focus on the allegations of race discrimination, as opposed to general issues of fairness and due process. It is essential that any investigation into claims of possible race discrimination should be conducted with the highest degree of clarity and rigour by investigators who are competent and appropriately trained. Senior management and the Advisory Board should satisfy themselves that this is the case.

5.8 Various new and replacement policies have been introduced by PHE since Dr. Oshin's case, designed to clarify procedures and to avoid the difficulties identified by the Tribunal. Some of these may well address the recommendations in this report. The original MPS policy was well out of date even when used in Dr. Oshin's investigation. The MPS policy was revised between 2014 and 2015, although the earlier version was used throughout with respect to Dr. Oshin. The new MPS arrangements, known as 'Responding to Management Concerns' (RTMC), describe the policy, procedures, and timescale, and also provide five sets of related guidance. A matrix is included to help ensure consistency in identifying the severity of professional performance concerns. This work was fully reviewed by PHE's independent employment law advisers, DAC Beechcrofts. The policy clearly states that all doctors must be treated fairly, transparently and consistently. Its introduction early in 2018 was delayed to take account of the Tribunal outcomes and findings. RTMC also complies with current employment legislation; ACAS best practice; the Equality Act 2010; and the Civil Service Code. It takes account of the professional standards required by the GMC. My recommendations will act as a lens for further scrutiny of the RTMC policy.

5.9 PHE has made clear statements to the effect that it aspires to a culture of openness and non-discriminatory behaviour. This infers appropriate training, communication arrangements, and visible champions, together with benchmarking against similar organisations. All Case Managers, Case and Panel Chairs are and will be trained based on NCAS guidance and this must be refreshed through regular Continuous Professional Development (CPD). All PHE staff undertake 'Equality and Diversity' training every three years. Anonymised or hypothetical case studies may assist the training and development process. All HR staff involved in supporting professional performance investigations must be trained in investigative processes. Training is important, but, in the light of the Tribunal's findings, how will the organisation know if it is effective in dealing with discriminatory behaviour? PHE has a comprehensive dashboard of HR indicators and these, plus others if necessary, should be deployed to monitor the impact in practice. In completing an ongoing audit, it is essential to guard against a 'tick-box' culture, validating such information through the use of other evidence.

5.10 It is possible that some managers found Dr. Oshin challenging, although this may have been born out of frustration on his part. The new Diversity and Inclusion Strategy invites challenge and seeks to create an environment where it is not only safe to challenge but is expected of all staff. The Diversity and Inclusion Management Development Programme, scheduled for launch in late 2018/19, will include all 1,300 Line Managers and above.

5.11 PHE has done much since the Tribunal case to strengthen its people related policies and procedures, not least with respect to race discrimination. These new arrangements require rigorous implementation and monitoring. Senior Mangement and the Advisory Board should keep the matter under close scrutiny, documenting how they do so in the minutes of their meetings.

Appendix 1

SEQUENCE OF EVENTS (drawn primarily from the evidence considered at the ET)

It is essential to understand the context of this case to make sense of my observations, conclusions, and recommendations. The Tribunal's deliberations and findings are in the public domain. Nevertheless, I am providing the following 'timeline' as an outline summary of the sequence of events. This will allow readers of the Report to appreciate the circumstances surrounding the Tribunal case and provides background to my conclusions and recommendations.

Dr Oshin was employed by PHE or its predecessor, the Health Protection Agency, from 7th December 2009 to 31st July 2015 as a Consultant in Public Health Medicine. The events prior to April 2013 occurred during the lifetime of the Health Protection Agency, which was then incorporated into Public Health England.

TIMELINE

December 2010

There was an incident in which a nurse complained that Dr. Oshin had shouted at her. This was not substantiated. Managers found that the nurse had made similar claims about other staff and the investigation was dropped. Dr. Oshin understood that this matter was in the past until it was raised in February 2014 in the context of 'serious concerns' about his behaviour.

September 2011

Dr. Oshin was asked to work one or more days a week at the Acute Response Centre (ARC) Office in Exeter. His normal base was St. Austell, a distance of approximately 75 miles from the ARC. He requested some adjustment to work arrangements, either as time off in lieu or additional pay. This was declined on the basis that attendance at the ARC was part of his contractual obligations.

October 2012

Dr. Oshin received an email (details not available) from the Director of the Health Protection Agency's South West Region in post at the time (later absorbed into PHE in 2013), which was critical of him and had been copied to others. He felt this was undermining and inappropriate and raised it with the senior member of staff concerned. The SW Regional Director responded with an apology in **January 2013.**

January 2013

Dr. Oshin was the subject of a further informal investigation following concerns that he had not followed due process in relation to an 'innovations' project' and also for taking time off in lieu for travel. This was considered inappropriate by the then SW Regional Director and other senior medical managers. The investigator apparently concluded that there should be

a follow-up meeting between Dr. Oshin, his Line Manager and HR to resolve the travel issues, although I have not seen any documentary evidence to substantiate this. Dr. Oshin was also advised apparently to follow standard Line Management arrangements regarding new areas of work. (Note: this was used in the subsequent MPS Investigation.)

March 2013

Dr. Oshin wrote to his Medical Line Manager providing his travel times from St. Austell to the ARC by way of an explanation for his shortened days at the ARC. His Line Manager said this was unacceptable, a decision upheld by the SW Regional Director, who felt that the requirement to attend a full day at the ARC was within his job description.

April 2013

The Human Resources Department wrote to Dr. Oshin stating that the matter had been considered by HR at the highest level and the local Director's decision had been upheld.

September 2013

Dr. Oshin wrote to his Medical Line Manager stating that he would no longer travel to the ARC in Exeter, as nothing had been done about either extra pay or time in lieu. He said he would fulfil his job responsibilities with respect to the ARC remotely from St. Austell. This working arrangement appears to have operated without further concerns being raised by managers.

December 2013

Dr .Oshin telephoned the ARC in Exeter on several occasions on the same day and asked two nurses to undertake some work. A dispute arose and Dr. Oshin was accused of bullying. The matter was not considered serious enough by managers for any form of investigation. Nevertheless, Dr. Oshin insisted that there should be an investigation to clear his name and requested that the 'Bullying and Harassment' Policy be used to do so.

December 2013

Dr. Oshin had his annual 360 degree Appraisal, which was positive.

February 2014

Following Dr. Oshin's own request for an investigation in the aftermath of the bullying allegations, the Human Resources Department contacted the National Clinical Assessment Service (NCAS), a division of the NHS Litigation Authority, who provide advice on matters of concern in relation to medical conduct or capability. The briefing to the NCAS specialist by HR subsequently turned out to be incorrect on several counts, but nevertheless resulted in a conclusion that the 'Medical High Professional Standards' (MHPS) arrangements should be used to carry out the investigation. The first stage is to determine whether there is a case to answer. PHE has its own local version of MHPS, which does not differ in substance and is designated 'Managing Professional Standards' (MPS). The decision to use MPS, rather than the 'Bullying and Harassment' Policy, was in line with extant policy as well as the external advice from NCAS. The new PHE Director for Devon, Cornwall and Somerset (Centre Director

of South West) was involved in organising the investigation, making recommendations to the Case Manager about Terms of Reference and the witnesses to be called.

Later in February 2014

The Case Manager wrote to Dr. Oshin stating that 'serious concerns' had been raised by Dr. Oshin's Centre Director, namely (a) the 2013 allegation of bullying, (b) safety cover for the ARC in Exeter, and (c) Dr. Oshin's working practices. The Case Manager acknowledged explicitly that some of these concerns were founded on hearsay, not fact.

March 2014

At this stage a Case Investigator was appointed. Such individuals must have been trained to NCAS standards in the appropriate investigation procedures under MPS. He was assisted by a senior HR Manager and an External Independent Person. The Case Investigator determines the facts of the matter and reports to the Case Manager, who decides whether there is a case to answer.

Later in March 2014

The Case Manager set the Terms of Reference (ToR) for the investigation under Part 2 of the MPS procedures and shared these with Dr. Oshin. Dr. Oshin contested the ToR and, at this stage, he learned for the first time that a report of the initial investigation in 2010 had been placed on his personal file. Although this investigation had concluded that there was no fault to be found, the report stated that there had been communication difficulties on both sides. Despite the determination of no fault, this nevertheless formed part of the subsequent Case Investigator's Report to the Case Manager.

May 2014

Dr. Oshin wrote to the Director of HR and the Case Manager asking for clarification of the allegations of bullying against him and requesting the written statements. The Case Manager responded and said there was only one statement available and that the other two allegations would be dealt with as part of the investigation. Dr. Oshin wrote later in **May 2014** to the External Independent Person (EIP) expressing concern about the procedure, indicating that it was not fair and transparent and that he felt there was a hidden agenda. The EIP said he could not comment on the ToR as this was beyond his remit. (Note: The Tribunal concluded that there was no evidence of any effective oversight or scrutiny by the EIP.)

July 2014

Dr. Oshin wrote to the Case Manager asking to whom he should address his concerns, if not the EIP. I have been unable to ascertain if there was a response to this request.

October 2014

The Case Investigator's Draft Report was sent to Dr. Oshin. The Report was headed '*Case investigation report into allegations of poor performance and capability by Dr Oshin'*. Despite the title, the Tribunal pointed out that the investigation was into conduct issues, not poor performance. The report highlighted 'serious concerns' and concluded that 'Dr. Oshin's behavioural issues' should be addressed by a remediation plan and reaffirmed the decision that he should attend the ARC in Exeter when on duty. It later transpired that the Terms of Reference adopted by the Case Investigator were in fact Draft Terms of Reference, not those agreed by the Case Manager. When this was pointed out by Dr. Oshin, the Case Investigator nevertheless would not alter them. In evidence to the Tribunal, PHE accepted that the case investigation process was not of an adequate standard.

November 2014

Dr. Oshin commented on the Case Investigator's Report and findings in a thirty-page critique. This referred to the uncritical acceptance of 'hearsay' and the inclusion of unsubstantiated 'facts'. The Investigator's Report was not amended in the light of Dr Oshin's observations, other than his dates of employment, although the thirty-page critique was attached as an appendix.

January 2015

Dr. Oshin received a generic email sent to all staff about Voluntary Exit (VE).

Later in January 2015

Dr. Oshin met with his new Line Manager (from May 2014) to discuss work matters and the closure of the St. Austell Office. At this meeting his Line Manager said that the Centre Director had suggested he might like to consider VE, which had just been made available to staff who met the qualifying criteria. The indications are that this was suggested with the best of intentions on his Line Manager's part, given Dr Oshin's perceived unhappiness with his situation and the closure of the St. Austell Office. Dr. Oshin placed a different interpretation on the suggestion, not least as the instigation of the proposal had come from the Centre Director, who might have had some difficulty in making the economic case for VE given the criteria involved.

Late January 2015

Dr. Oshin initiated a race discrimination grievance, stating that he was being targeted by senior staff within the organisation. On the same day he registered his interest in VE.

March 2015

In early March the Case Manager met with Dr. Oshin in London to tell him the outcome of the Case Investigation. The decision was described as a favourable outcome with no disciplinary action required, but that there were nevertheless 'serious issues' with Dr. Oshin's behaviour and that he would be sent on a course, the focus of which would be 'better communication'. Dr. Oshin refused to accept this outcome on the basis that the entire investigation had been flawed and that he felt he was being patronised, a view not shared by the Case Manager. Dr. Oshin was advised later in March by letter that the course was on 'behavioural coaching'.

April 2015

Dr. Oshin met the Senior Manager who would hear his Grievance, an individual who had not previously been involved. Stage One of the Grievance was held and adjourned by agreement to allow for further investigation. It was agreed that the report would be finalised prior to Dr. Oshin's departure from PHE.

April/May 2015

Dr. Oshin continued to contest the Case Investigator's report, seeking clarification on a range of matters including the specific behavioural issues requiring modification referred to by the Case Manager.

May 2015

Dr. Oshin wrote to HR and his Line Manager stating that he wanted to contact his local MP about the closure of the St. Austell Office. The reply from HR said that this was privileged information and any disclosure might be in breach of the Civil Service Code. Dr. Oshin then wrote to the Centre Director, his Line Manager and the Regional Director stating that he was not convinced by the advice from HR and that he had arranged to meet his MP. HR responded to this by sending him the entire PHE Code; Dr. Oshin said that he could not fathom which parts were relevant.

May/June 2015

HR emailed various senior staff, including the Case Manager, saying that if it transpired that Dr. Oshin was in breach of contract as a result of contact with his MP, this might have an impact on his request for VE. Dr. Oshin had made it clear that he would only accept VE if his grievance was heard. Dr. Oshin met his MP in early June.

June 2015

Dr. Oshin was advised that his revalidation date was 10th September and a recommendation to revalidate would be made on his behalf. This process is managed under the auspices of the Responsible Officer (explanatory note at Appendix 2). Dr. Oshin's revalidation recommendation was submitted to GMC at the end of the month. PHE advised Dr. Oshin by email that this had been sent.

At the end June, PHE's Chief Executive received a letter from the local MP about the closure of the St. Austell Office.

Early July 2015

An acknowledgement was received from GMC on 1st July. The recommendation that Dr. Oshin's revalidation should proceed was then withdrawn pending clarification as to whether contact with the local MP was in line with PHE's Code of Conduct. The Deputy Responsible Officer wrote the same day to Dr. Oshin to explain the situation regarding his revalidation,

adding that this did not change his status as a licensed doctor and did not mean his revalidation had been deferred, merely that he been returned to his original revalidation date of 10th September 2015. The decision to take this course of action was based on advice from the GMC.

Dr. Oshin lodged his claim with the Employment Tribunal the same day.

Several days later the Responsible Officer wrote to Dr. Oshin about the withdrawal of the recommendation regarding revalidation, adding that he would be in further contact regarding Dr. Oshin's meeting with his local MP. The RO drafted a second letter one week later, but this was not sent as a result of the Chief Executive's decision that no action should be taken against Dr. Oshin about the meeting with his MP.

Late July 2015

Dr. Oshin's grievance was not upheld. The Grievance Report was shared with Dr Oshin and he was invited to a meeting with the Grievance Chair. Dr Oshin declined and lodged an appeal two days later.

Dr Oshin left PHE at the end of the month.

September 2015

The Appeal was heard by a very senior Medical Manager, not previously associated with any of the issues above. The matter was dealt with by reference to papers only. The Grievance Appeal was not upheld.

Appendix 2

ROLE OF THE RESPONSIBLE OFFICER

Responsible officers have an important statutory role in medical regulation. The successful implementation of revalidation depends to a considerable degree on the competence and skills of those doctors carrying out this role.

As a responsible officer you are accountable for the local clinical governance processes in your particular healthcare organisation, focusing on the conduct and performance of doctors. Your duties include evaluating a doctor's fitness to practise and liaising with the GMC over relevant procedures.

It is your job to make recommendations; but the decision on whether a doctor should be revalidated belongs to the GMC, as the regulator.

You will also liaise with the GMC on individual fitness to practise cases, where you judge that national sanctions may be required.

It is important that you understand the local context and are on hand to act to remedy low level problems at an early stage. You'll also ensure that the organisation has appropriate systems for appraising the performance and conduct of doctors. This local focus and a closer link with the GMC will deliver a system that is fairer to doctors and safer for patients.

Professor Richard Parish,

Review Chair,

October 2018

IN STRICTEST CONFIDENCE

Addendum to an inquiry carried out by Professor Richard Parish, CBE following the Employment Tribunal involving

Dr. B. Oshin and Public Health England

Capsticks Solicitors LLP
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INTRODUCTION

We have been instructed by Alex Sienkiewicz, Director of Corporate Affairs at Public Health England to prepare an addendum to an inquiry report prepared by Professor Richard Parish, CBE following an Employment Tribunal case involving Public Health England and Dr B. Ohsin.

The scope of our instructions was to undertake a desktop review of relevant documentation in order to address some of the Terms of Reference set by Professor Parish for his inquiry.

The Inquiry's Terms of Reference, as determined by Professor Parish, were as follows:

1. To consider whether the arrangements in place governing investigations under the Maintaining High Professional Standards (MHPS and MPS) procedures are equitable and fair to doctors from all backgrounds.

2. To review the arrangements for an individual being investigated under MPS to ensure that she or he can raise concerns and /or issues about the proposed Terms of Reference.

3. To consider whether there are adequate processes in place to ensure that the individual being investigated can make representations on the report prepared by the Case Investigator before a decision is made by the Case Manager and/or Responsible Officer.

4. To determine the adequacy of the arrangements for ensuring that all staff involved in the process are trained appropriately, act objectively and remain up to date.

5. To determine whether there are robust, transparent and fair policies and procedures in place in reaching decisions about medical revalidation, including transparency of communication with the GMC as the professional regulatory body.

6. To clarify the arrangements for appeal should a recommendation regarding medical revalidation be in dispute.

7. To review the arrangements for appealing a stage one decision in the grievance process in circumstances where an employee is about to leave or has actually left the organisation.

8. To review this case in the light of Dr. Oshin's experience and the Tribunal's findings and make recommendations for organisational improvement.

9. To consider the governance and accountability arrangements regarding the above and, if necessary, to recommend how these should be strengthened.

FINDINGS

1. **The arrangements in place at PHE governing investigations under the Maintaining High Professional Standards (MHPS and MPS) procedures are equitable and fair to doctors from all backgrounds.**

2. **Both the national MHPS and local MPS documents adequately make provision for raising concerns and /or issues about the proposed Terms of Reference for an investigation.**

3. **The PHE local MPS policy goes beyond the terms of the national MHPS framework and contains a specific right for the practitioner to review the report before the case manager makes a decision on how to proceed.**

4. **The PHE MPS policy includes a requirement that all employees participating in the process should be trained in equality and investigation processes.**

5. **The policies in place at PHE for revalidation and appraisal are robust, fair and transparent.**

6. **The Appraisal Policy at PHE (appendix 7) clearly outlines the complaints process for practitioners that are not satisfied with their appraisal process. Although the document does not specifically mention revalidation and refers to appraisal the two are so intrinsically linked that we consider it is reasonably clear that this process would apply to both appraisal and revalidation processes.**

7. **Neither PHE's grievance procedure nor the ACAS Code of Conduct address the scenario where a grievance appeal is still pending after the employee has left their employment. It is a moot point as to whether local grievance procedures should allow for rights of appeal after the employee has left their employment.**

1. To consider whether the arrangements in place governing investigations under the Maintaining High Professional Standards (MHPS and MPS) procedures are equitable and fair to doctors from all backgrounds.

The national MHPS policy published in 2003 by the Department of Health does not make any statement regarding the application of the policy to doctors from different backgrounds. We were also unable to locate any equality impact assessment (or reference to one being carried out) which would have highlighted any issues within the document that may be cause for concern in its application to doctors from different backgrounds.

Having said that, the MHPS policy contains procedural safeguards that would apply if any concerns were raised regarding the application of the process to doctors from different backgrounds. Specifically, the policy provides for the appointment of a Designated Board Member to oversee the case and ensure that momentum is maintained. In addition, where an investigation is required, the MHPS policy provides for an appropriately experienced and trained person to be appointed as case investigator.

In relation to PHE's local MPS policy (which is an adaptation of the national policy) there is a statement contained within the document titled 'Addressing concerns about medical and dental practitioners in PHE' which was issued in 2017. The statement can be found on page 8 of the document, section 5 'Equality Analysis' which informs the reader that the impact of the policy on those with protected characteristics has been considered in line with the Equality Act. The statement reads:

'The duties of PHE, both in its mission to reduce inequalities and as an employer under the Equalities Act, have been considered in the production of this policy. The outcomes of this policy may be subject to an Equality Analysis to maintain its effectiveness'.

We have not been provided with information about any Equality Analysis which may have taken place since this policy was developed.

Additionally in Appendix A titled 'Managing Concerns about Doctors and Dentists' page 12 section 5 has a statement regarding Equal Opportunities and stipulates that

those involved in the process including the case manager and case investigator will have received equal opportunities training .

It is therefore clear that:

- PHE has considered its MPS policy in line with the Equality Act;
- The MPS policy includes the provisions as set out in the national MHPS framework to have an independent officer overseeing the investigation and to whom the practitioner can make representations;
- In the MPS policy this person should be external to the organisation and this may therefore be seen as offering more independence to that of a designated board member in the event of concerns being raised by a doctor from a different background;
- Those carrying out functions under the MPS policy are expected to have undergone equal opportunities training.

We therefore conclude that the arrangements in place at PHE governing investigations under the Maintaining High Professional Standards (MHPS and MPS) procedures are equitable and fair to doctors from all backgrounds. It is not within the scope of our review to comment on how those arrangements may have been applied in any specific case.

2. To review the arrangements for an individual being investigated under MPS to ensure that she or he can raise concerns and /or issues about the proposed Terms of Reference.

As indicated above, the role of the designated board member in the national MHPS guidance is to carry out an independent oversight role, and this includes receiving representations from the practitioner in respect of exclusion from the workplace, or the raising of concerns regarding the investigation of a case if these are not provided for by the NHS body's grievance procedures (see MHPS Part II paragraph 13).

In PHE’s local MPS policy, this role is undertaken by the external independent person, to whom concerns about the process and the terms of reference can be

raised (Addressing concerns about medical and dental practitioners in PHE, part 2, page 14).

We therefore conclude that both the national MHPS and local MPS documents adequately make provision for raising concerns and /or issues about the proposed Terms of Reference for an investigation.

3. To consider whether there are adequate processes in place to ensure that the individual being investigated can make representations on the report prepared by the Case Investigator before a decision is made by the Case Manager and/or Responsible Officer.

The national MHPS policy provides that the practitioner must be informed in writing by the case manager as soon as it has been decided that an investigation is to be undertaken. They should also be informed of the name of the case investigator and made aware of the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the case investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied (MHPS Part I paragraph 13).

The PHE MPS policy has provision for the practitioner to review the report and make comment on the factual findings contained within it before the case manager makes a decision about how the matter should progress, (see part 3, para 4.2, page 19 of Addressing concerns about medical and dental practitioners in PHE).

Therefore, in respect of processes for ensuring that the individual being investigated can make representations on the report prepared by the Case Investigator before a decision is made by the Case Manager and/or Responsible Officer the PHE local policy goes beyond the terms of the national MHPS framework and contains a specific right for the practitioner to review the report before the case manager makes a decision on how to proceed.

4. To determine the adequacy of the arrangements for ensuring that all staff involved in the process are trained appropriately, act objectively and remain up to date.

The PHE MPS policy states that all employees participating in this process should be trained in equality and investigation processes. We have not seen any information from PHE evidencing whether all parties in Dr Ohsin's case were up to date or not. We recommend that PHE reviews the training that has been provided to staff involved in MPS processes in order to ensure that they continue to meet the requirements of the local MPS policy.

5. To determine whether there are robust, transparent and fair policies and procedures in place in reaching decisions about medical revalidation, including transparency of communication with the GMC as the professional regulatory body.

PHE's relevant policy for consideration of this point is called 'the Medical Revalidation Policy'. The policy sets out clearly the options available to the responsible officer for making decisions regarding revalidation but does not set out a prescriptive process for how a decision is reached (para 6.4). The policy does set out the requirements and processes in place for communicating with the GMC.

In addition, PHE's Annual Professional Appraisal Policy sets out clearly the process for appraisal for medical staff. It includes on page 7 the Quality Assurance process and in section 4 of the 'Supporting Guidance notes for Annual Appraisal in PHE' it gives a good account of selecting an appraiser including a mechanism for assuring that there is no bias between appraiser and appraisee as well as timescales for reflective practice to change information following an appraisal by the appraisee. The document goes on to set out step by step the process and timescales involved in the appraisal process and the complaints process if a practitioner is dissatisfied with the process. Any complaints received of this nature are collated under the Quality Assurance process and detailed within the annual report for PHE, showing a good level of transparency.

We therefore find that the policies in place at PHE for revalidation and appraisal are robust, fair and transparent.

6. To clarify the arrangements for appeal should a recommendation regarding medical revalidation be in dispute.

As mentioned above the Appraisal Policy at PHE (appendix 7) clearly outlines the complaints process for practitioners that are not satisfied with their appraisal process. Although the document does not specifically mention revalidation and refers to appraisal the two are so intrinsically linked that we consider it is reasonably clear that this process would apply to both appraisal and revalidation processes. In order to achieve greater clarity we recommend that the Appraisal Policy is amended to state explicitly that the complaints process can be used to raise concerns about a recommendation in respect of medical revalidation. Similarly, the Medical Revalidation Policy should cross-refer to this section of the Appraisal Policy in respect of such concerns.

7. To review the arrangements for appealing a stage one decision in the grievance process in circumstances where an employee is about to leave or has actually left the organisation.

Whilst employees are entitled to pursue a grievance appeal at any time during the course of their employment, neither PHE's grievance procedure nor the ACAS Code of Conduct address the scenario where a grievance appeal is still pending after the employee has left their employment.

The focus of local grievance procedures is to seek to resolve workplace concerns promptly and as informally as possible. It is therefore a moot point as to whether local grievance procedures should allow for rights of appeal after the employee has left their employment. On the one hand, continuing with a grievance process may enable the employer to comply with safer recruitment standards (to provide factual references). On the other hand, the options available to the employer to resolve the grievance in a meaningful way after the employee has left their employment may be limited.

8. To review this case in the light of Dr. Oshin's experience and the Tribunal's findings and make recommendations for organisational improvement.

9. To consider the governance and accountability arrangements regarding the above and, if necessary, to recommend how these should be strengthened.

These terms of reference are outside the scope of this addendum and we refer to Professor Parish's inquiry report in respect of them.

ANNEXE B

IN THE MATTER OF

THE REPORT OF A TRIBUNAL OF ENQUIRY INTO EMPLOYMENT ISSUES AT PUBLIC HEALTH ENGLAND

OPINION

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1. I am instructed on behalf of Public Health England ('PHE') to undertake a desk-top review of a report prepared by Professor Richard Parish, which was commissioned by PHE in response to a recommendation made by an Employment Tribunal sitting in Exeter ('the Tribunal'). That recommendation arose from claims brought against PHE by Dr B Oshin, a Consultant in Public Health Medicine formerly employed by PHE. In a judgment on liability sent to the parties on 16 January 2017, the Tribunal upheld Dr Oshin's claims for (amongst other things) race discrimination and victimisation. The Tribunal then made the recommendation which gave rise to Professor Parish's report in a remedy judgment sent to the parties on 10 May 2017.

2. I have been provided with a copy of Professor Parish's report in draft (though I understand that this represents his final substantive conclusions). I have also been provided with an addendum to that report prepared by my instructing solicitors, which addresses various aspects of Professor Parish's terms of reference relating to PHE's policies and procedures (and which I understand was commissioned by PHE in light of concerns about Professor Parish's capacity to complete this work due to ill health). I have also been provided with copies of relevant policies and procedures of PHE.

3. PHE wishes to obtain assurance that Professor Parish's report (supplemented by the addendum prepared by my instructing solicitors) has satisfactorily fulfilled the Tribunal's recommendation and reached sound conclusions, and to determine whether there are any further steps which PHE should consider in light of the Tribunal's judgments and Professor Parish's report.

4. In those circumstances, I am asked to advise one the following matters:

    4.1. Whether Professor Parish's report (supplemented by the addendum) has satisfactorily addressed the Tribunal's recommendation;

    4.2. Whether (based on a desk-top review of the material with which I have been provided) Professor Parish's findings and recommendations appear reasonable and consistent with his terms of reference; and

    4.3. Whether there are any outstanding issues that I consider ought to be addressed in order to fulfil the Tribunal's recommendation.

Background: the Tribunal's findings of discrimination and victimisation

5. The background facts concerning Dr Oshin's case are set out in some detail both in the Tribunal's liability judgment and in Dr Parish's report. Repetition of them would serve no purpose other than to increase the volume of material to be considered by anyone wishing to review these matters. I therefore gratefully adopt and rely on the Tribunal's factual findings at paragraphs 77-191 of its liability judgment, together with the summary 'Timeline' set out in Professor Parish's report.

6. It is, however, relevant to note the nature and basis of the Tribunal's core liability findings in relation to Dr Oshin's claims for direct race discrimination and victimisation, because those findings constitute the essential context against which the Tribunal's recommendation must be understood. The Tribunal's core findings in relation to direct race discrimination and victimisation (at paragraphs 207-221 of its liability judgment) may be summarised as follows:

    6.1. There was a series of unreasonable or improper decisions and actions taken in respect of Dr Oshin by a number of different individuals which, viewed collectively, suggested that they were the result of hostility or vindictiveness based on perceptions of him that had developed at a group or institutional level. It could be inferred from this that the treatment of him was subconsciously influenced by

race, and PHE had failed to prove otherwise. The treatment was in that sense the result of discriminatory *'group think'* or *'institutional discrimination'*.

6.2. That course of directly discriminatory treatment comprised:

(a) the multiple faults which the Tribunal had found occurred during the investigation conducted under PHE's policy for addressing concerns about doctors, entitled *'Maintaining Professional Standards'* ('MPS') (including use of the wrong policy, use of the wrong terms of reference, failure to allow Dr Oshin reasonable input into the process either as to the terms of reference or by way of comments on the accuracy of the final report, inadequate conduct of the investigation, failing to verify hearsay evidence, repeatedly and wrongly asserting a course of conduct which was not supported by the evidence, and asserting that Dr Oshin's capability was in issue when it was not);

(b) imposing a non-appealable direction that Dr Oshin should undergo behavioural coaching;

(c) Dr Oshin's resignation in response to those matters (which amounted to a constructive dismissal); and

(d) the subsequent failure properly to consider his grievance appeal.

6.3. The evidence did not, however, support the conclusion that Dr Oshin had been stereotyped as an *'angry black man'* or that negative perceptions had developed because of his accent. Nor did the evidence support the conclusion that those from a black or minority ethnic background were more likely than white colleagues to face investigation under PHE's MPS policy.

6.4. As to victimisation, the decision to withdraw revalidation for Dr Oshin was done (in part) in response to the issue of proceedings in the Tribunal (as well as being a response to his contact with his MP about the closure of PHE's St Austell office, which the Tribunal held would have constituted a protected act for the purposes of

the 'whistleblowing' provisions in Part IVA of the Employment Rights Act 1996, had Dr Oshin made such a claim, which he had not).

The Tribunal's recommendation

7. The Tribunal's remedy judgment records that Dr Oshin was seeking an external investigation to ensure that *'lessons had been learned and things would change'* (paragraph 19). It goes on to record that, following a suggestion by the Tribunal and discussion between the parties, the parties were able to agree on the terms of a recommendation which were acceptable to both, and the final recommendation was accordingly made by consent (paragraph 25).

8. The recommendation made was as follows:

> **'The Tribunal recommends that the Respondent commissions a report from Professor Richard Parish, who, having been given a copy of the liability and remedy decisions of this Tribunal, is to be asked to set his own terms of reference for an enquiry which he is to be asked to chair, and he is to appoint those he considers best to assist him as a tribunal of enquiry, and that tribunal is to make recommendations arising from that enquiry.'**

9. Professor Parish explains in his report that his name appears in this recommendation because he had been identified during the discussions between the parties at the remedy hearing as a suitable person to conduct the enquiry envisaged by the recommendation. As was known to the parties and the Tribunal at the time the recommendation was agreed and made, Professor Parish is a member of PHE's Advisory Board, which provides strategic, operational and governance advice to PHE and comprises non-executive members such as Professor Parish as well as members of PHE's executive management team. Professor Parish explains, however, that he completed his review and report in an *'independent capacity'*.

The meaning and effect of the recommendation

10. In a narrow sense, the only step which PHE needed to take in order to comply with the Tribunal's recommendation was to commission a report from Professor Parish and that

has plainly been done. However, I understand that the assurance which PHE is seeking is broader than that: it seeks an assurance as to whether Professor Parish's report (together with the addendum produced by my instructing solicitors) satisfactorily addresses the underlying purpose of the recommendation.

11. Whilst it may not strictly be necessary in order to comply with the recommendation in a formal sense, it is no doubt right for PHE to wish to satisfy itself that the underlying purpose of the recommendation has been satisfactorily addressed as a matter of policy and good governance.

12. The recommendation is drafted in very broad terms. In order to identify its underlying purpose and assess whether it has been satisfactorily addressed, it is therefore necessary to understand the legal framework and parameters within which its meaning and effect fall to be considered.

13. The power pursuant to which the Tribunal made the recommendation is contained in section 124 of the Equality Act 2010, which at the material time[1] provided (so far as relevant) as follows:

> **124. Remedies: general**
>
> (1) This section applies if an employment tribunal finds that there has been a contravention of a provision referred to in section 120(1).
>
> (2) The tribunal may—
>
> …
>
> (c) make an appropriate recommendation.
>
> (3) An appropriate recommendation is a recommendation that within a specified period the respondent takes specified steps for the purpose of obviating or reducing the adverse effect of any matter to which the proceedings relate—
>
> (a) on the complainant;
>
> (b) on any other person.

[1] Section 124(3) has subsequently been amended, with effect in relation to any proceedings commenced on or after 1 October 2015, to restrict the purpose of any recommendation to obviating or reducing the effect of any act of discrimination on the complainant him- or herself. Dr Oshin's claim was presented on 1 June 2015 and the wider, unamended provisions therefore continued to apply.

14. It will be apparent that the Tribunal's recommendation did not, as required by s124(3), specify the period within which the respondent must comply. It is also, in my view, doubtful whether a recommendation to commission an individual to take *unspecified* steps of his own devising sufficiently meets the requirement to set out the *'specified steps'* to be taken by a respondent.

15. Since the recommendation was made by consent and has not been challenged or appealed, it must be treated as valid. Nevertheless, the lack of specificity beyond the commissioning of a report from Professor Parish makes it difficult to assess the adequacy of what he has subsequently done. It is necessary to derive the criteria for that assessment from the background.

16. It is clear from section 124(3) that a recommendation must focus on the effect of *matters to which the proceedings relate* and must be for the purpose of obviating or reducing their effect either on the complainant or on any other person. It is also clear that the matters *'to which the proceedings relate'* must be understood as referring to proceedings under the Equality Act 2010, not to any other claims that may have been brought within the same claim form.

17. Thus, the purpose of the recommendation in this case must be understood as being concerned with the acts of direct race discrimination and victimisation upheld by the Tribunal, as summarised above. Moreover, since Dr Oshin was no longer employed by PHE, the recommendation to commission an enquiry and report in relation to PHE must have been directed towards obviating or reducing the adverse effect of those matters on other people, rather than on Dr Oshin himself. That is consistent with the reason why Dr Oshin himself indicated he was seeking a recommendation: to ensure that lessons had been learnt and things would change (see paragraph 7 above).

18. In my view, it follows that in order to assess whether Professor Parish's report (together with the addendum prepared by my instructing solicitors) satisfactorily addresses the underlying purpose of the Tribunal's recommendation, the question to be asked is whether that report (together with the addendum) contains a reasonable and

proportionate exploration and analysis of ways to obviate or reduce the risk of acts of discrimination or victimisation of the kind upheld by the Tribunal being repeated.

Professor Parish's terms of reference

19. The recommendation left it entirely to Professor Parish to set his own terms of reference. Nevertheless, he considered it appropriate (in my view rightly) to discuss the matter with both PHE and Dr Oshin to obtain their views and see if agreement could be reached. Unfortunately, consensus was not possible. Dr Oshin's view was that Professor Parish should conduct an enquiry into '*institutional racism*' at PHE. Professor Parish disagreed. He gives two reasons: first, that the findings of discrimination were a matter for the Tribunal; second, that it was more appropriate for Professor Parish to focus on how best to minimise the chances of similar discrimination occurring again.

20. In my view, Professor Parish was right to adopt the approach he did for essentially the reasons he gave. Although the Tribunal found that the discrimination against Dr Oshin had occurred as a result of '*group think*' at an institutional level, it did so in the context of making findings about the particular course of discriminatory conduct about which Dr Oshin had complained. It did not make a broader finding that PHE is 'institutionally racist' (nor could it, given its function to hear a specific case), and it expressly rejected Dr Oshin's wider allegations of racial stereotyping and disproportionate use of the MPS procedure against black and minority ethnic employees.

21. It is those findings, and the statutory basis for the recommendation, which provide the context, and set the proper parameters, for Professor Parish's review. Understood in that context, it would not have been appropriate for Professor Parish to embark upon a fresh enquiry into whether there is *broader* discrimination within PHE: the findings of discrimination were a matter for the Tribunal. Professor Parish's role, pursuant to the statutory purpose of the recommendation, was to consider measures to obviate or reduce the risk of a repetition of the discrimination that happened to Dr Oshin, not to embark on a general enquiry about possible *other* discrimination which the Tribunal had not made findings about.

22. The specific terms of reference adopted by Professor Parish, set out in section 3 of his report, are in my view appropriately focused on the objective of minimising the risk of repeating the discrimination that happened to Dr Oshin. Essentially, they follow the Tribunal's findings of discrimination and focus on identifying procedural and governance measures that would reduce the risk repeating the improper acts which the Tribunal found amounted to discrimination against Dr Oshin. Thus the terms of reference focus on identifying:

    22.1. Measures aimed at avoiding repetition of the faults which occurred in the use and conduct of the MPS process in relation to Dr Oshin (terms of reference 1-4);

    22.2. Measures aimed at avoiding repetition of the improper withdrawal of revalidation (terms of reference 5-6);

    22.3. Measures aimed at avoiding repetition of the failures in respect of Dr Oshin's grievance appeal (term of reference 7); and

    22.4. Finally, any more general organisational and/or governance measures that would help to ensure compliance with the more specific measures identified under the other terms of reference and reduce the risk of repeating the improper and discriminatory use and application of the procedures in question (terms of reference 8-9).

23. Given their systematic focus on the Tribunal's findings of discrimination and on measures to obviate or reduce the risk of repeating that discrimination, the terms of reference adopted by Professor Paris are in my view reasonable and appropriate.

The process adopted by Professor Parish

24. Professor Parish conducted interviews with staff at PHE on a confidential basis and used these as a basis for making his recommendations. He then shared his draft report with various people, including in particular a fellow non-executive member of the PHE

Advisory Board and an independent member of its Audit and Risk Committee, in order to test its accuracy, relevance and legal compliance.

25. It is unclear whether this process is quite what was envisaged by the recommendation. The language of the recommendation, which refers to Professor Parish appointing others to assist him as a *'tribunal of enquiry'*, might imply that what was envisaged was a more formal hearing process before a panel. However, although this *might* have been what was envisaged, the terms of the recommendation are again so vague and ambiguous as to provide little helpful guidance. As with the terms of reference, they essentially leave the process to Professor Parish. The discretion to appoint *'those he considers best to assist him'* must encompass a discretion both as to the number (if any) of those from whom he sought assistance and the nature of that assistance. Similarly, the work of a *'tribunal of enquiry'* may involve a variety of investigative processes. The recommendation left the determination of those processes up to Professor Parish.

26. The reasons which Professor Parish gives for the process which he adopted are, on their face, reasonable. He explains in his report that he felt he was more likely to obtain candid and helpful answers if he conducted interviews on a confidential one-to-one basis. He goes on to say that having conducted those interviews, he has been reinforced in his view that that was the right way to proceed because the information he obtained was *'extremely helpful'* in helping him to understand relevant failings and guiding him towards potential solutions and he considers that more formal hearings before a 'panel' would not have succeeded to the same extent in getting *'under the skin'* of the relevant events and issues because staff would have felt inhibited in speaking frankly.

27. There is no reason to doubt Professor Parish's assessment of the efficacy of the process which he adopted. His rationale for that process is focussed on the correct objective, namely facilitating his ability to identify effective measures to minimise the risk of repeating the discrimination that happened to Dr Oshin. The assistance which he then sought from (amongst others) the wider PHE Advisory Board was within the scope of his discretion to determine what assistance would best help him achieve that objective.

28. Overall, therefore, it is my view that the process adopted by Professor Parish was within the broad discretion conferred on him by the recommendation and was ostensibly reasonable. Ultimately, the objective of the recommendation was not procedural but substantive: identifying measures to obviate or reduce the risk of repeating the discrimination that happened to Dr Oshin. What matters in the end is whether the process adopted by Professor Parish has resulted in recommendations which reasonably address that objective. It is therefore to that central question that I now turn.

Professor Parish's recommendations

29. I am not in a position, by way of a desk-top review, to repeat the substantive exercise carried out by Professor Parish for the purpose of saying whether I agree or disagree with his analysis and recommendations, and I am not asked to do so. I do not have the benefit of the full and detailed understanding of the organisation and the underlying issues that Professor Parish will have obtained through the interviews he conducted and the other assistance to which he refers in his report.

30. Having concluded that his terms of reference and approach satisfactorily address the Tribunal's recommendation, my role is to review Professor Parish's recommendations (as supplemented by the addendum prepared by my instructing solicitors) in order to provide an assurance (or not) that they appear reasonable and address the purpose of the Tribunal's recommendation as reflected in his terms of reference.

31. The approach which I therefore propose to adopt is to consider the extent to which each of the elements of the discrimination found by the Tribunal is addressed by Professor Parish's recommendations and, in each case, assess whether there are any obvious deficiencies or omissions. The headings under which the following analysis is carried out therefore reflect the key elements of the Tribunal's findings of discrimination, as summarised at paragraph 6 above (which are also reflected in Professor Parish's terms of reference, as discussed in paragraph 23 above).

Use and application of the MPS process

Appropriate use of MPS versus other policies

32. In Dr Oshin's case, PHE had already determined that allegations made about his behaviour on 5 December 2013 were not sufficiently serious to require formal investigation. It was Dr Oshin who requested an investigation, under the bullying and harassment policy, in order to 'clear his name'. In those circumstances, it was plainly inappropriate to use the MPS process and, in my view, it is doubtful even that it was appropriate to accede to Dr Oshin's request for a formal investigation at all: initiating any formal process risked treating the allegations disproportionately to the view that had already been taken about their seriousness. It appears from the Tribunal's findings that it was from this point, and perhaps precisely because of the disproportionate emphasis given to the allegations by commencing a formal investigation, that subconscious discrimination began to creep into PHE's handling of the matter. In general, ensuring consistency and proportionality in the use of formal and informal processes is an important aspect of avoiding discrimination: one risk of inconsistency in that regard is that initiation of a formal process where it is disproportionate to do so might itself imply a degree of seriousness that is not objectively warranted and thus risks reinforcing any pre-existing subconscious prejudices.

33. The following recommendations by Professor Parish address these matters:

    33.1. Recommendation 1 crucially stresses the importance of applying the principle of proportionality to any situation. I note that PHE's grievance and MPS[2] policies all already emphasise the importance of considering informal action before initiating a formal investigation. I have not seen a copy of the bullying and harassment policy, but assume that (as is usual) this does the same. When implementing this recommendation, PHE should review all these policies to ensure clarity about when it is appropriate to move to a formal process, and when not.

[2] The current version of the MPS policy, issued in November 2017, is entitled *'Responding to and managing concerns: Addressing concerns about medical and dental practitioners in PHE'*, but for consistency and convenience I will continue to refer to it as the 'MPS policy'.

33.2. Recommendation 3 addresses the need for clarity about the interrelationship between different policies.

34. In my view, these recommendations are reasonable insofar as they go. However, it would also in my opinion be sensible to give some consideration to oversight and monitoring of consistency in relation to these matters: conferring a discretion on individual managers or HR advisers to decide whether to resolve an issue informally or under one policy rather than another, even applying criteria set out in the policies, leaves open a risk of inconsistency and potential discrimination. In my view, in implementing these recommendations PHE should give consideration to the most effective and practical method(s) for monitoring and ensuring consistency on these matters and should include provision in that regard in the relevant policies. One possibility would be to require consultation with a senior manager (e.g. the HR Director) whenever a decision is taken to proceed to a formal investigation, so that a single senior manager has a good overview of how the discretion is being exercised across the organisation so as to monitor and ensure consistency. It may also be appropriate and sensible to record all decisions about whether to proceed formally or informally, identifying the relevant protected characteristics of the subjects. Collating and reporting those data (anonymously) to the Board could then form part of the monitoring covered by recommendation 6 (see below). However, these are suggestions and I would not wish to be prescriptive; only to suggest that consideration is given to these issues alongside the general implementation of recommendations 1 and 3.

Setting terms of reference

35. In my view, recommendation 4 reasonably addresses the problems which occurred in setting the terms of reference in Dr Oshin's case.

Reliance on historic and/or hearsay matters

36. The risk of relying on historic and/or hearsay matters in relation to potential discrimination is that doing so can encourage reliance on impression and collective or institutional views that may have built up over a period of time, rather than on factual

evidence about specific current concerns. This can allow greater space for subconscious discrimination to influence the process and conclusions – as exemplified by what the Tribunal found happened in Dr Oshin's case. Inappropriately grouping separate incidents under a single investigation can similarly allow greater space for subconscious discrimination to influence the general characterisation or perception of the overall issues, as opposed to objective consideration of the individual issues on their own merits.

37. Nevertheless, it is important that an employer such as PHE should be able to identify and address patterns of inappropriate behaviour where they *genuinely* and objectively can be seen to have persisted over a period of time, even though individual incidents may not previously have merited formal action. Striking the right balance therefore requires care and proper safeguards.

38. In my view, recommendations 4and 5 reasonably address these matters and appear to strike the right balance. They address the need for accuracy and transparency in the records kept; prohibit the use of uncorroborated hearsay evidence; provide that as a general rule separate issues should be addressed independently and historic matters not resurrected; but allow for collective consideration of different incidents or historic background where there is a genuine overriding reason to do so and with appropriate safeguards (transparency, the requirement to obtain the input of the External Independent Person, an opportunity for the subject of the investigation to contest the approach, and a requirement not to be selective in the use of historic reports).

39. PHE will clearly need to consider how best to implement these recommendations by way of a review of its policies and practices (not only the MPS policy itself, but also including in relation to the content and retention of material in personnel files, which will now also have to take account of its obligations under the General Data Protection Regulation), and any necessary training for individuals.

Improper conduct of the investigation: investigator making findings as opposed to recommendations and reaching conclusions (as to 'course of conduct') not supported by the evidence

40. In my view, recommendation 2 adequately addresses these issues: NCAS has national expertise in the conduct of investigations of this kind and is a suitable partner to ensure that anyone who undertakes the role of Case Investigator is appropriately trained.

Opportunity to challenge final report

41. The MPS policy already provides for a right of the practitioner to comment on the draft investigation report before the Case Manager takes a decision about how to proceed. That in fact happened in Dr Oshin's case, and the failure which occurred was that neither the Case Investigator nor the Case Manager adequately considered or applied their minds to the reasonable and legitimate criticisms made by Dr Oshin.

42. In my view, the final paragraph of recommendation 4 reasonably addresses that issue by requiring the Case Manager, in his or her final written decision, explicitly to address any concerns raised by the practitioner in relation to the draft investigation report. PHE will need to ensure that the policy is reviewed and amended to reflect this and that measures are taken to ensure that the requirement is then complied with (i.e. training of potential Case Managers and HR advisers).

Categorisation of concerns

43. In my view, recommendation 4 reasonably addresses this issue. The classification of concerns into conduct or capability (or both) is a matter of law and is not always straightforward (see e.g. Mattu v University Hospitals Coventry and Warwickshire NHS Trust [2013] ICR 270). In cases of uncertainty, it may therefore be sensible to obtain legal advice on the appropriate classification at an early stage in order to ensure clarity.

Use of informal action (which cannot be appealed)

44. The ability to deal with a concern through informal action, even following a formal investigation, is clearly an important facility and is not to be discouraged. However, since by its nature informal action is not susceptible to a formal appeal, it is important to guard against the risk that it is used where formal concerns have not been upheld, in a way that nevertheless leaves an improper implication of impropriety hanging over the practitioner that may have been influenced by subconscious discrimination as opposed to objective analysis of the evidence. This is what appears to have happened in Dr Oshin's case.

45. In my view, the penultimate paragraph of recommendation 4 reasonably addresses this issue by requiring the External Independent Person to review the process, with a particular focus on any potential discrimination or bias, before the Case Manager reaches his or her decision. Insofar as it is not clear already from this recommendation, this should in my view include the Case Manager sharing his or her proposed decision with the External Independent Person (whether that is to take informal action, or proceed to a formal disciplinary or capability hearing, or some other action) so that the External Independent Person may also scrutinise that proposed decision.

General oversight and governance measures

46. Procedural safeguards of the kind to which the majority of Professor Parish's recommendations are directed can only go so far: even if all procedural requirements are impeccably followed, the risk of group or institutional perceptions of an individual, which may have developed over time, influencing a process or a decision in a way that is tainted by subconscious discrimination will inevitably remain. Involving someone with appropriate training in and understanding of the risks in that regard, who is able to provide an independent and authoritative voice within the process to challenge such perceptions where there appears to be a risk that they are having an effect, is therefore an important additional safeguard. If implemented in a way that results in active scrutiny and participation by such an individual, as opposed to simply being a 'tick box' in which the individual is named in a letter but is never actually involved, then a

safeguard of this kind may, in practice, be the most important and effective measure in reducing the risk of discrimination, such as that experienced by Dr Oshin, being repeated in the future.

47. For those reasons, the second paragraph of recommendation 4 (coupled with the specific additional responsibilities identified for the External Independent Person in recommendations 4 and 5) not only reasonably addresses the fundamental problems revealed by the Tribunal's findings of discrimination but is in my view probably the most important of Professor Parish's recommendations. I would note and endorse the comment in the addendum prepared by my instructing solicitors that the independence from the organisation of the person appointed to this role is a safeguard which goes beyond the equivalent safeguard in the national 'MHPS' process that is generally applied in NHS Trusts (pursuant to which the equivalent role is fulfilled by a non-executive member of the board, rather than someone wholly independent of the organisation). Strengthening the role of the External Independent Person therefore represents an important safeguard under PHE's process, which is warranted in light of the Tribunal's findings of discrimination in relation to Dr Oshin.

48. What Professor Parish does not do in recommendation 4 is to specify precisely how the role of the External Independent Person should be *'enhanced'*, how the process of appointment and responsibilities should be *'clarified'*, or what the *'prescribed'* elements of their training should be. In my view, it would be helpful to have more detail in relation to these matters so that PHE can both understand more precisely what Professor Parish has in mind and can ensure adequate implementation of this recommendation. I recommend inviting Professor Parish to provide further particulars of these elements of this recommendation, but would in any event myself recommend that:

    48.1. The 'enhanced' nature of the role should be reflected in specific amendments to the policy to confirm the *obligatory* involvement of the External Independent Person in the matters addressed by recommendations 4 and 5, together

with the access to the PHE Chair, Chief Executive and Responsible Officer addressed in recommendation 4;

48.2. The appointment process should be clarified to establish express criteria for the appointment of External Independent Persons, which should expressly include as a mandatory criterion relevant training in, and experience of, identifying and addressing issues of discrimination. PHE may also wish to give consideration to instituting a panel of ready-approved External Independent Persons to facilitate the appointment of a suitable person in any individual case;

48.3. The responsibilities of the External Independent Person should be expressly defined in the policy and should be expressly communicated upon each appointment in an individual case. Those responsibilities should expressly include an obligation to consider at each stage of the External Independent Person's involvement in a process whether there is any evidence that might indicate discrimination, including as a result of subconscious or collective bias or prejudice.

Revalidation

49. Recommendation 6 in my view largely addresses the issues which arose in relation to revalidation in Dr Oshin's case. It also addresses a concern that Professor Parish clearly identified that the revalidation is not well understood generally outside the medical profession and that the Tribunal may not in this instance have fully understood it. I am not sure that this is entirely fair to the Tribunal because (as Professor Parish himself recognises) the withdrawal of revalidation for Dr Oshin was not simply the result of the Responsible Officer drawing to the attention of the GMC concerns that he had not choice but to notify, but happened because the Responsible Officer decided that something was a matter of concern when in fact it should not have been at all, and in doing so he was materially influenced by Dr Oshin's tribunal claim.

50. Whilst the recommendation to consider dividing the responsibilities of Case Manager and Responsible Officer would go some way towards addressing this, I would (not being an expert in the revalidation process myself) question whether it is really

obligatory for a Responsible Officer to raise *any* alleged 'concern' with the GMC, or whether s/he ought in fact to exercise a degree of independent judgment about whether something is genuinely a matter of concern capable of affecting revalidation. PHE's policy on revalidation (and indeed the role of the Responsible Officer as outlined in Professor Parish's report) would appear to indicate that the exercise of such judgment is not only possible but required. Thus, in Dr Oshin's case, had the Responsible Officer been someone different from the Case Manager, then s/he could and should have considered whether Dr Oshin's contact with the MP was even capable of constituting a legitimate matter of concern and, having done so, ought to have concluded that it was not and so was not therefore a matter that needed to be raised with the GMC at all.

51. I would therefore suggest that in addition to amending the MPS policy to indicate that (so far as practicable) that the Case Manager in relation to any concerns about an individual practitioner should be someone other than that practitioner's Responsible Officer, the revalidation policy should also be reviewed and amended (perhaps after consultation with the GMC about the appropriate terms) to indicate the extent to which the Responsible Officer should exercise independent judgment about any alleged 'concern' that is drawn to his or her attention and the circumstances in which s/he is *not* then required to raise that with the GMC.

Grievance appeals after the end of employment

52. Recommendations 4 and 6 in my view reasonably address the issues which arose in relation to the grievance process in Dr Oshin's case, subject to the following caveat.

53. Since Professor Parish's report and recommendations are, by definition, concerned solely with minimising the risk of repeating the kind of *discrimination and victimisation* which occurred in relation to Dr Oshin, the recommendation that a grievance appeal should *always* include a 3-person panel with the composition recommended (which I note is consistent with PHE's existing grievance policy), even if conducted after the employee has left, should be understood as applying to grievances which relate to allegations of discrimination or victimisation (including discriminatory harassment). In relation to grievances of that kind, it is my view that Professor Parish's

recommendation *should* be followed even where the employee has left because, as discussed above in relation to the role of the External Independent Person, careful scrutiny of potential discrimination with independent input is an important safeguard against the kind of subconscious discrimination by way of institutional 'group think' which occurred in relation to Dr Oshin. Indeed, the knowledge that any such allegations will be taken seriously and addressed through a process which involves an appeal of this kind may itself constitute a powerful inhibiting factor in relation to such discrimination occurring in the first place.

54. However, since grievances may vary considerably in their subject matter and context, in the absence of any issue of discrimination or victimisation, it *may* not be necessary to complete a full-blown grievance appeal in relation to *every* grievance even where the employee has left employment with PHE. Detailed advice on the obligations and risks in relation to a grievance appeal in those circumstances is outside the scope of this Opinion, though I note my instructing solicitors' observations in that regard in the addendum prepared by them. I would observe that, generally, it is advisable to offer *some form* of grievance appeal even where an employee has left, but following the full process set out in the procedure that applies to current employees *may* not always be necessary. Apart from grievances relating to alleged discrimination or victimisation, which I have addressed above, I would recommend that PHE takes advice on a case-by-case basis about what is reasonable and advisable where an employee has left the organisation.

Other general governance and oversight

55. Recommendations 5 and 6 address other more general aspects of governance and oversight which arise from what happened to Dr Oshin and in my view do so reasonably (relating to the need for an affective and transparent appraisal process to underpin the revalidation process; and the need for clarity about the application and effect of the Civil Service Code in relation to the right of medical staff to communicate concerns about patient safety externally).

56. Finally, recommendation 6 sensibly recommends a proactive approach to monitoring and oversight of the implementation and operation of anti-discrimination measures more generally. It perhaps goes without saying, but it would seem obvious that in the immediate future the recommended six-monthly reports to the Board should include an action plan for the implementation of Professor Parish's recommendations (as supplemented by the addendum prepared by my instructing solicitors and by this Opinion), which should indicate the precise measures to be taken, who has responsibility for each, and the timescale within which it is anticipated each will be completed. It is to be noted that a number of the procedural safeguards recommended by Professor Parish are already reflected in PHE's current policies, as outlined in the addendum prepared by my instructing solicitors. Where this is the case, to ensure robustness and clarity, I would recommend that the action plan should nevertheless identify the point, but can then record at the outset that the relevant policy already reflects the recommended position and so no further specific amendments are required.

57. The action plan should then be updated on a rolling basis as the relevant steps are completed. The Board should assure itself that the action plan adequately reflects the recommendations (as supplemented), monitor the implementation process, and take appropriate action if it is not implemented promptly and effectively.

Conclusion

58. For the reasons set out above, it is my view that:

58.1. Professor Parish's report has satisfactorily addressed the Tribunal's recommendation in its terms of reference, process and recommendations;

58.2. Professor Parish's findings and recommendations appear reasonable based on the information available to me and consistent with the terms of the enquiry;

58.3. For the purpose of implementing Professor Parish's recommendations, I have noted some supplementary suggestions or caveats in relation to particular recommendations in the course of the discussion above: see in particular paragraphs 34, 39, 42, 45, 48, 51, 53-4 and 56-7. Of these, PHE may wish to

consider obtaining Professor Parish's supplementary comments in relation to the matters discussed at paragraph 48, though this may not be necessary if PHE considers that it can address his recommendations adequately, when supplemented with the additional guidance that I have set out in that paragraph.

58.4. Aside from those matters, there are not in my view any outstanding issues to be addressed in order to fulfil the Tribunal's recommendation.

59. If there are any further matters arising, I hope my instructing solicitor will not hesitate to contact me.

BEN COOPER QC

15 November 2018

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IN THE MATTER OF

THE REPORT OF A TRIBUNAL OF

ENQUIRY INTO EMPLOYMENT ISSUES

AT PUBLIC HEALTH ENGLAND

OPINION

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ANNEXE C

Public Health England

Protecting and improving the nation's health

Management's response to the enquiry by Professor Richard Parish following an Employment Tribunal between Dr. B. Oshin and Public Health England

November 2018

1.0 Introduction

In October 2016, an Employment Tribunal heard a case against Public Health England (PHE) brought by Dr. B. Oshin, which was followed by a remedy hearing in April 2017. The Tribunal found in favour of Dr. Oshin and, as part of the remedy hearing, recommended that PHE should commission a review from Professor Parish to terms of reference set by him.

Professor Richard Parish carried out this review and submitted his final report and recommendations to PHE on 31 October 2018.

This document set out PHE management's response to Professor Parish's report and provides a direct response to the recommendations contained in the report as well as any other information deemed relevant to the issues raise in his report. It has been prepared by the Chief People Officer and her team in partnership with colleagues in the Office of the PHE Responsible Officer (ORO), who lead on medical HR issues.

2.0 Further background

Dr Oshin was employed initially by the Health Protection Agency and subsequently PHE as its successor body. He was employed on Medical and Dental terms, analogous to those of the Medical & Dental consultant contract in the NHS, and as a medically qualified public health practitioner. Matters that related to professional performance were dealt with by the Responsible Officer (RO) in keeping with the Responsible Officer Regulations (2010, amended 2013[1]) and the case itself was managed under PHE's policy 'Maintaining Professional Standards in PHE for Medical and Dental Staff' (MPS). Dr Oshin left PHE at the end of July 2015.

Following receipt of the reserved judgement in February 2017 (which followed the October 2016 hearing), the ORO reflected on the judgement and identified three key areas that needed consideration and which would form part of the wider policy review being undertaken. These areas were: timescales for investigation and the general investigation process itself; the role of the External Independent Person (EIP); and how to deal with investigations when complaints are made against doctors in PHE. The Director for Health Protection and Medical Director directly assumed the RO responsibilities in 2017.

As a result of the above concerns a lessons learned paper, with accompanying action plan, was developed and submitted to PHE's Revalidation Steering Group for review, comment, oversight of the issues contained in the paper, and to ensure that the action plan was being implemented appropriately.

A new PHE policy 'Responding to and Managing Concerns: Addressing Concerns about Medical and Dental Practitioners in PHE' (RTMC) and associated supporting guidance has also been approved and published following the outcome of this Employment Tribunal. This policy is available at Appendix A.

[1] http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

3.0 PHE's commitment to Diversity and Inclusion

The Tribunal concluded that there had been '*unconscious race discrimination'* on PHE's part and that the investigation into Dr. Oshin's conduct, which had been carried out by an independent person who had an honorary contract with PHE, had fallen *'between the Scylla and Charybdis of utter incompetence and subconscious discrimination'*. The Tribunal also criticised PHE management for what it described as *'group think'* and *'institutional discrimination'.*

The Tribunal conclusions are very concerning to us as an organisation, and it is clear that there is more which can be done to drive our Equality and Inclusion agenda to ensure it is truly embedded into the culture of PHE. It was re-assuring to see that Professor Parish acknowledged in his report that we have done much since the Tribunal case to strengthen our people-related policies and procedures.

We value the diversity of our workforce and have a comprehensive and engaging approach, which was recognised by inclusion in the 2018 Best Employers for Race list. The list acknowledges employers who are taking a comprehensive and strategic approach to tackling racial inequalities as part of their overall work on diversity and inclusion.

We also have a number of vibrant and active staff networks that help to support the work in this area. The Black, Asian and Minority Ethnic (BAME) network recently supported Black History Month with a series of events that were open to all staff. The network also helps support talent and development schemes and a number of candidates were recently put forward to participate in Business in the Community mentoring circles, aimed at BAME staff.

PHE's Diversity and Inclusion team also ensures that internal Civil Service schemes, such as the Future Leaders Scheme and Positive Action Pathway, are promoted through the networks and their profile raised in under-represented groups. The team seeks to ensure that PHE is an exemplar and follows best practice. Over the course of the last 12 months our organisation has made significant progress on the Stonewall Workplace Equalities Index and has secured Disability Confident Leadership Status.

A dashboard showing PHE's diversity data is available to all staff and this helps us shape our strategy and determine if the various interventions and initiatives, such as setting diversity and inclusion objectives for all senior managers, are gaining traction.

4.0 Response to the recommendations

The next section of this report will respond directly to the recommendations as set out in Professor Parish's report.

Recommendation 1 – Early Intervention to Resolve Issues

We have made a number of improvements in light of what we have learnt from this tribunal and our regular internal reviews.

Our goal is to respond to issues as early as possible, whether these are raised formally or informally. Intervention is usually carried out at a local level, and many problems are resolved at this early stage.

The new RTMC policy specifically highlights that early intervention is the best course of action. It emphasises that line managers are responsible for dealing with performance issues as quickly as possible and preferably at the informal stage. To ensure ease of understanding, there are a number of flow charts and a scoring grid in the new policy that help to set out more clearly how such issues should be dealt with when they are raised with managers.

The PHE Grievance policy has been updated and specifies that mediation should always be considered first when resolving disputes or workplace conflict between staff without the need to pursue a formal path. This follows the industry standard practice outlined by ACAS and is supported by the CIPD, the professional body for HR practitioners.

Additionally, PHE has developed a workplace mediation service, which is advertised on the intranet (PHEnet), and an employee guide to mediation is readily available on PHEnet. This guide includes an 'Introduction to Mediation' document which clearly outlines what mediation is and how to access the service. Furthermore, whilst mediation is best used informally it can still be used once formal processes are underway to agree a way forward between parties.

The mediation service has been widely advertised to line managers and staff networks, as well as specifically to PHE's "Engagement Agent" network. This network consists of individuals around the organisation who support and encourage better organisational health within PHE.

In response to demand, we are currently training an additional 12 mediators and will be introducing further feedback to ensure that the mediation service remains appropriate for PHE.

We are mindful that there is always a need to balance the desire to resolve issues early and locally against concerns from line managers about effects on others within the team or department and re-assurance of colleagues involved that issues have been dealt with appropriately. The seriousness of an allegation also impacts upon the level at which the concern is dealt with.

<u>Recommendation 2 – Training of Those Involved in Case Work</u>

All Case Investigators who carry out investigations under the RTMC policy are trained by NHS Resolution (previously called the National Clinical Assessment Service), as are all Case Managers. There is also an ongoing development programme for Case Investigators and Case Managers; this already covers and will continue to cover enhanced diversity and inclusion training.

Everyone carrying out investigations under either PHE's Grievance Policy and Procedure or PHE's Disciplinary Policy and Procedure is trained internally by colleagues in the People Directorate.

A training programme is currently being implemented for all staff above Civil Service Grade 6 (or equivalent). Individual investigators are now asked to undertake the Civil Service Learning training course on Managing Disciplinary and Grievance Cases prior to commencing an investigation.

Work is underway to further integrate diversity and inclusion into PHE's working practices, including signposting of further training on unconscious bias into line manager training modules. The aim is to ensure that diversity and inclusion forms an integral part of a line manager's day to day role.

PHE is seeking to engage an external provider to deliver a bespoke training event for the Senior Leadership Team to ensure that they are all trained appropriately and aware of their responsibilities under the Equality Act when commissioning and deciding on investigations into claims around race discrimination.

Recommendation 3 – Ensuring Policies and Procedures are Easily Understood.

As detailed above, a training programme is being rolled out across PHE, most recently with the Centre Directors. Feedback from these training sessions indicate a common theme concerning the importance of setting out how various policies related to performance and conduct interconnect and operate in practice, especially when claims of bullying and harassment are raised. PHE are investigating how this issue can be addressed and will include the ORO, NHS Resolution, the GMC and staff side colleagues in this review.

The new RTMC policy includes a number of diagrams that help set out the process and procedural flow more clearly and feedback has already been received confirming this has helped when working through and interpreting the policy.

Work is under way to develop a Standard Operating Procedure (SOP) between HR, the ORO and Occupational Health for multifaceted cases that may concurrently involve disciplinary action, grievances and periods of absence, as well as cases involving professionally registered members of staff. This SOP will ensure that all those involved in the process are aware of their responsibilities and how concerns and/or issues can be flagged or escalated to more senior colleagues as appropriate.

Recommendation 4 – Conduct of Investigations

The recommendation that separate issues should be investigated independently needs to be balanced against inadvertently subjecting a member of staff to additional stress by carrying out a number of different investigations for issues that are intrinsically linked. Professor Parish has highlighted that the most important consideration is that Terms of Reference for an investigation are explicit and only extended where further issues come to light that are related to the initial investigation. When new issues are raised that are unconnected to ongoing investigations then these should be investigated separately. We accept this recommendation.

Under PHE policy, individuals under investigation have the right to comment on the Terms of Reference when they meet with the Case Manager at the start of the investigation, and to request that the Case Investigator interview additional identified witnesses.

The development of the new RTMC policy took those issues into account and specifically incorporated lessons from this Employment Tribunal. As a result, PHE has enhanced and clarified the role of the External Independent Person (EIP) and both EIPs currently identified are senior medically qualified colleagues from NHS England.

The ORO ensures that there is no conflict of interest between the EIP and the case under investigation. Furthermore, the EIP has direct access to the Chief Executive and the Responsible Officer. Dr Parish's recommendation that the EIP has direct access to the Chair of the PHE Board is under consideration.

The Case Manager, when preparing and then finalising the Terms of Reference, must make sure that the final version of the Terms of Reference used in the investigation are signed and dated by both the practitioner and the Case Investigator. To that end, the Case Manager will not usually share the Terms of Reference with the Case Investigator at a draft stage to avoid the confusion that occurred in the FO investigation. The EIP should be sent the draft Terms of Reference at the start of the process and invited to comment, particularly in relation to clarity. The final, signed, Terms of Reference should be sent to the EIP at the start of the investigation.

The ORO has taken steps to improve the governance of decisions taken, including those made by Case Managers on receipt of a Case Investigators report, by establishing a Responsible Officer Advisory Group (ROAG). This Group has membership from both the lay community and from another Designated Body. The Case Manager will normally consult with the ROAG before making a final decision on next steps.

In seeking the advice of the ROAG, the Case Manager should explicitly identify any concerns raised by the practitioner following their receipt of the draft investigation report.

<u>Recommendation 5: Use of Documents Relating to Prior Investigations.</u>

When individuals are subject to formal processes carried out under PHE's Disciplinary Policy and Procedure for non-Medical and Dental staff, the policy states that:

> *12.2 If the disciplinary proceedings result in dismissal, the records will be held for a period of two years after dismissal, unless there is a specific reason to retain the records for a longer period of time.*
>
> *12.3 However, if it is decided at the conclusion of the disciplinary investigation (or on completion of disciplinary proceedings) that there is no case to answer, the records will be destroyed.*

This is currently under review with PHE's Information Governance team to ensure that the policy remains appropriate for all circumstances.

With regards to Medical and Dental staff, the ORO maintains records of concerns raised in order to deliver the role of the Responsible Officer as defined in the RO Regulations. It should be made clear to the practitioner that such records are not kept on their personal file.

Reference to previous investigations in file notes must only be made for good reason and it should always be made explicit what the outcome of that investigation was.

PHE agrees that where earlier reports are deemed relevant to a current investigation, they should be used in their entirety and only redacted to protect confidential information. This will be embedded into practice. The Case Investigator should consider seeking the advice of the ORO before including findings and reports from previous investigations

PHE's Grievance Policy and Procedure states the following:

> *Section 15(g) There is no provision for grievances to be dealt with once PHE employment has ended. However, if an ex-member of staff raises a concern, PHE will investigate and take appropriate action.*

The grievance process focuses on resolution and ensuring that the concerns of complainants are considered in a fair and appropriate manner, in line with PHE policy. When a respondent has left the organisation there is no avenue for redress and therefore no potential resolution to the complaint. However, in order to provide some degree of resolution for complainants, it is common practice in PHE is for the grievance process to complete, albeit via correspondence rather through formal face to face meetings. It is important to ensure that this common practice continues and is followed consistently across the organisation.

<u>Recommendation 6 – Quality Assurance</u>

Annual professional appraisal, as determined by the GMC, focuses on a reflective approach to a medical practitioner's fitness to practice, including evidence of active participation in continuing professional development. The annual professional appraisal is not the vehicle for the identification of professional or other performance concerns: but appraisers are trained to identify and deal with such situations by halting the appraisal immediately and seeking the advice of the ORO. PHE has always maintained a rigorous approach to the quality assurance of its appraisal process, which has recently been strengthened further.

PHE currently quality assures the outputs of the professional appraisal process using a specially developed and carefully evaluated internal quality assurance tool, PAQUAT, and currently reviews 50% of all appraisals. The final appraisal undertaken before revalidation is always quality assured, as are appraisals undertaken by new appraisers and appraisals where a concern has been raised. In addition, a small number of randomly selected appraisals are also reviewed.

All professional appraisers are trained by Regional Appraisal Leads (who are themselves trained by the ORO), who in collaboration with the ORO run regular networking and updating sessions for all appraisers. Appraisal training uses a clear and consistent set of materials which have been developed since the introduction of revalidation in 2013, and are founded on materials originally developed by the NHS Revalidation Support Team.

PHE engages, once every five years, in an external quality assurance process wherein the entire RO function, associated processes and policies, is reviewed by an external team from a Higher Level RO office, usually a regional NHS England team. Following this process, an

Action Plan is produced, the implementation of which is overseen by PHE's Revalidation Steering Group. PHE's ORO has also developed a peer review relationship and quality assurance process with NHS Blood and Transport to further improve its processes and policies.

PHE recognises the need to ensure that investigation reports are of a high quality and that this extends to those produced by the ORO. To that end, the following arrangements have been put in place:

- all Case Investigators undertaking an investigation for the first time will be allocated an experienced investigator to support them through the process, including the preparation of the investigation report.

- the experience of the members of ROAG will be utilised and the ROAG will be asked to review the quality of all investigation reports it receives.

PHE works closely with its General Medical Council Employer Liaison Advisor, who is made aware of current investigations. If PHE is concerned that there may be implications for an individual's registration or revalidation, the advice of the GMC ELA is sought and the case referred to the GMC if necessary. It is regrettable that it was not made clear to the Employment Tribunal that an MPS (or now RTMC) investigation does not impact directly upon an individual's registration or revalidation.

PHE's RO makes recommendations to the GMC regarding a medical practitioner's revalidation, based on the outputs of annual professional appraisals and additional clinical governance intelligence; however, it is the GMC that revalidates the practitioner. PHE is currently updating its revalidation policy and as part of this, a new appeals process has been included into this policy. The new, recommended appeals process is as follows:

> *'Complaints should be raised in the first instance with the ORO. Every effort should be made to resolve the issue informally, but if this is not possible, the practitioner should raise the issue with the Responsible Officer for PHE's RO, i.e. the Chief Medical Officer for England'.*

5.0 Conclusions

We were concerned by the outcome of this Employment Tribunal and have invested significant effort since the outcome to improve processes, specifically when concerns are raised and investigated against our medical and dental staff.

Additionally, there has been a focussed drive to improve our commitment to Diversity and Inclusion across the organisation and to ensure that all our staff feel supported at work.

In particular, we have: overhauled policies; improved training; produced a dashboard for monitoring purposes; and reviewed available data sources to identify trends and develop targeted interventions where appropriate.

The vision of the Diversity and Staff Inclusion team is to ensure that all staff feel that they are '*working in an environment where you can bring all of yourself, every day to a workplace which is fair, inclusive, safe and supportive'.*

Finally, PHE is working hard to ensure that it is a great place to work and stay, and a place where everyone can do their best work. This is driven from the top, with the Chief Executive expecting all our staff to *'put decency towards each other as a marker of how we wish to be known and to challenge or report whenever bad behaviour is experienced or witnessed'.*

6.0 Action plan

An accompanying action plan, incorporating all of the changes and processes improvements highlighted within this report is available at Appendix B.

It is recommended that this action plan should be reviewed on a regular basis by the PHE Management Committee, the senior executive decision making body within PHE. We propose that progress should be reported periodically to the Audit and Risk Committee of the PHE Advisory Board, subject to review and agreement by the Chair of the ARC.

Responding to and managing concerns:

Addressing concerns about medical and dental practitioners in PHE

Policy number

Date of issue: November l 2017

Date of Review: November l 2019

Document code: Version: 01.00

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1. INTRODUCTION

1.1 This policy and Appendix 1 of this policy describes how conduct, capability and health concerns ("Concerns") about medical and dental practitioners are to be managed within Public Health England (PHE). This policy complies with the requirements of regulation 10 of The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013) in relation to establishing and implementing procedures to investigate concerns.

1.2 PHE is committed to providing a public health service of the highest quality and believes that all medical and dental employees understand fully the need to perform well in their roles and contribute effectively to the PHE mission, values and behaviours. Nevertheless, there are occasions when Concerns arise and support may be needed in relation to those Concerns to restore and maintain an effective contribution to work.

1.3 This policy applies to all doctors and dentists employed by PHE, whose conduct, capability or health could possibly give cause for concern and further clarity is required.

1.4 Failure to address Concerns can result in inefficiency, at both the individual and corporate level, as it can lower morale and engagement throughout the rest of the workforce. All managers must address misconduct or poor performance, through good line management practice, with the aim of improving professional performance including conduct, capability or health. This includes, but is not limited to, making effective use of the Personal Development Review (PDR) process and its associated policies and Annual Professional Appraisal. Where managerial support has failed to result in performance at the required standard, this policy should be applied.

1.5 Understanding conduct, capability or health difficulties at an early stage can be challenging for line managers when they may not have often dealt with such issues. In order to support managers with this task this policy should be used in conjunction with the relevant supporting sets of guidance notes, especially in the initial stages, when trying to determine if the matter under consideration is a conduct, capability or health issue. It is important to take a consistent, fair and transparent approach across the organisation and it is recommended that as a starting point, line managers use the assessment tool which can be found within the supporting guidance notes - **Identifying conduct, capability or health concerns in doctors and dentists in PHE.**

1.6 Poor performance can be described as: ‘a doctor or dentist whose performance at work falls below the expected performance required to carry out their role effectively.’ It may also occur when the doctor or dentist breaches the relevant GMC/GDC standards outside of work. Expectations of performance may vary depending on actual role, but will usually be related to:

- progress against agreed work objectives;
- competency frameworks for role;

- job descriptions;
- relevant regulatory body standards;
- the PHE code of conduct for all staff.

1.7 This policy should be read with reference to the PHE People Charter which outlines the values and behaviors expected of all PHE staff and underpins how all PHE policies should be applied.

2. POLICY STATEMENT

2.1 PHE recognises the importance of embedding PHE's Code of Conduct (which incorporates the Civil Service Code) and the PHE People Charter in the conduct and performance of all PHE employees. In recognition of this, this policy and the accompanying sets of guidance notes aims to be corrective, rather than punitive. There is an expectation that doctors and dentists will also adhere to the policies and procedures for all PHE staff with specific reference to the Grievance policy, Bullying and Harassment policy and general corporate responsibilities, such as time-keeping and diary management, recognising that should there be a conflict between a PHE policy and an individual's contract of employment, the contract takes precedence..

2.2 The aim of this policy is to support doctors and dentists to meet their professional standards as PHE employees. If the level of conduct, capability or health performance falls below acceptable standards, this policy (and accompanying sets of guidance notes) is designed to help managers motivate and encourage doctors and dentists to address and rectify these issues for their own benefit and that of PHE. However, if the practitioner's conduct, capability or health performance, despite interventions, continues to fall below the expected standard, this policy and procedure allows for formal action to be taken, leading to a range of options including no action, informal action, formal warnings and dismissal.

2.3 PHE will treat all doctors and dentists fairly and consistently and will ensure employees and managers understand the policy and associated sets of guidance notes. The policy is based on fair and transparent treatment of all medical and dental employees, and complies with: employment legislation; Advisory, Conciliation and Arbitration Service (ACAS) best practice; the Equality Act 2010; and the Civil Service Management Code. It also references the professional standards required by the General Medical Council and the General Dental Council.

2.4 The procedures for dealing with Concerns are set out in Appendix 1 to this policy.

2.5 Briefing sessions will be provided by the HR team to explain the application of the policy and supporting guidance notes. The policy will also be part of the induction pack for doctors and dentists.

3. RAISING CONCERNS

3.1 Concerns about a doctor or dentist's conduct, capability or health may be raised at any time and should be dealt with promptly. The issues should be initially discussed with the practitioner as quickly as possible, ideally within three working days. These issues may be varied in nature and severity but issues of patient and population safety take precedence over all other considerations.

3.2 Conduct, capability or health Concerns may emerge through the following routes, although this list is not exhaustive:-

- clinical governance processes
- significant events and serious incidents
- management and professional appraisal
- regular 1:1s
- colleagues raising issues, including whistleblowing
- complaints from colleagues, service users and third parties
- self-referral
- external bodies e.g. GMC/GDC, the Police

3.3 The practitioner's line manager is usually responsible for the early identification of conduct, capability or health issues. Concerns are usually initially considered by collation of such data in a structured manner which should enable the line manager working with the Service Lead or Centre Director to take an informed view on whether concerns should be escalated or whether the matter can be resolved informally within the immediate line management context. Once an issue is uncovered it must be dealt with using the appropriate mechanisms and not ignored.

3.4 The figure below demonstrates the usual pathway for progressing Concerns.

Initial concerns are raised regarding the practitioner usually with their line manager. Meeting held to discuss the issue.

Assessment made using guidance notes - **Identifying conduct capability or health concerns about doctors and dentists in PHE**

Discuss with HR Business Partner and Service lead/Centre Director to establish issues and to determine action to be taken – local resolution or escalation to the Chief Executive or Medical Director AND Office of the Responsible Officer as appropriate.

Informal action

Where informal intervention is decided on, ensure that regular discussions are held with practitioner. Support should be offered to the practitioner throughout. See guidance notes - Supporting **doctors and dentists with conduct or capability concerns in PHE**

Notes of discussions filed and shared with the Office of Responsible Officer for future reference if required.

Resolution achieved.

Case closed

Escalation of concerns

When informal resolution has failed or serious issues are identified the Chief Executive should appoint a suitably trained Case Manager who will determine whether a formal investigation is required. NCAS should be consulted for advice. A Case Investigator is appointed by the Case Manager and terms of reference drawn up. HR support is assigned to the case. The Case Manager and senior HR lead meet with the practitioner to explain process and terms of reference

The investigating team interview the witnesses and review any supporting evidence. The report is completed and sent to Case Manager for final decision making on next steps in process

Possible outcomes include:

1. a conduct hearing,
2. a capability assessment,
3. a remediation plan,
4. a capability hearing,
5. a formal referral to the relevant regulator,
6. a health matter that needs further support or
7. there is no case to answer

General points to consider

1. Confidentiality of the practitioner throughout
2. The influence of the working environment on conduct or performance
3. The process should be supportive and developmental rather than punitive
4. NCAS should be consulted throughout
5. Professional conduct is relevant both within and outside of the workplace at all times
6. The four sets of supporting guidance notes underpinning this policy

3.5 The usual response is for the line manager to meet with the practitioner as soon as possible - regardless of the nature of the problem. There may be a mixture of responses and proposed resolution outcomes from this meeting in keeping with the mixed nature of problems. A decision about appropriate next steps, including escalation if necessary, will be decided by the line manager and the Service Area Lead or Centre Director.

3.6 It is essential at this meeting to take a view on the evidence available at that time and to identify if this is a single incident or if it is part of a repeated pattern with previous related incidents.

3.7 If this meeting has an unsatisfactory outcome (ie the problem still exists or the situation has deteriorated) or if the matter is of a more serious nature, the Service Area Lead or Centre Director will refer the matter to the Office of the Responsible Officer, Chief Executive or Medical Director as appropriate. Where there are concerns about patient or population safety these will always be referred directly to the Responsible Officer and the Chief Executive and Medical Director.

3.8 Where the Responsible Officer / Medical Director and Chief Executive, working with the Service Area Lead or Centre Director, are unable to resolve the issues locally, the Responsible Officer / Medical Director and Chief Executive will determine if there will be a formal investigation into the Concerns. This process is covered in **Appendix A** of this policy.

3.9 This policy is supported by a series of underpinning guidance notes as follows**:**

- **Identifying conduct, capability or health concerns about doctors and dentists in PHE**
- **Supporting doctors and dentists with conduct, capability or health concerns in PHE**
- **Preparing for the investigation of concerns relating to conduct, capability or the health of doctors and dentists in PHE**
- **Remediating and developing doctors and dentists in PHE.**

An outline of the contents of each of these guidance notes can be found in **Appendix M**.

4. ROLES AND RESPONSIBILITIES

Unless otherwise stated, references to Responsible Officer means Case Manager under this Policy. **Appendix A** sets out the roles and responsibilities of the relevant individuals in relation to action to be taken regarding conduct, capability and health Concerns about doctors and dentists in PHE. In addition:

4.1 Each PHE director is responsible for ensuring that this policy is adopted in their directorate.

4.2 Line managers are responsible for:

(a) Dealing with performance issues as quickly as possible and preferably at the informal stage.

(b) Informing HR before any formal meeting has taken place. HR will retain records on each case.
(c) Ensuring that decisions in each meeting are normally taken by someone at least one grade higher than the individual to whom the concern relates or, in the case of individuals on consultant TSC or equivalent someone to whom the individual has managerial or professional accountability. This will normally be the individual's line manager.
(d) Ensuring that decisions about moving to a formal process are discussed with the individual's line manager.
(f) Working with HR to adhere to the indicative timings that are provided in this policy and procedure. All parties involved are responsible for ensuring these are met wherever possible. There may be circumstances where the timings described in the procedures need to be amended, for example allowing time for support and adjustments to become available or to take effect.
(g) Ensuring that that the requirements of the Data Protection Act 1998 are complied with when processing or retaining documents.

4.3 The Office of the Responsible Officer (ORO) will:
(a) Advise and assist line managers in recognising and resolving conduct, capability and health concerns in doctors and dentists at an early stage.
(b) Working with local / regional management and when remediation measures have been exhausted, or if the concern is of sufficient significance for immediate escalation to the RO, prepare an initial assessment report for the RO.
(c) Provide management support for professional performance investigations throughout the Case Management process.
(d) Ensure there is a sufficient cohort of trained and available suitably senior case investigators and case managers available.
(e) Support the Responsible Officer and Medical Director in discharging their responsibilities regarding conduct and performance concerns
(f) Co-ordinate meetings of a Decision Making Group to oversee case management across PHE for doctors and dentists.

4.4 The Chief Executive (CEO) is responsible for:
(a) Commissioning the formal investigation, following receipt of the initial assessment report.
(b) Ensuring that an appropriately trained Case Manager is appointed or delegating this task as necessary.
(c) Liaising with the Chairman in the appointment of an External Independent Person or other appropriate non-executive advisor for the investigative process.

4.5 The Responsible Officer (RO), working closely with the Medical Director (MD), is responsible for:
a) Making the decision on whether to proceed to formal investigation, following initial assessment.
b) Notifying the Chief Executive (CEO) and taking appropriate action should a serious concern be raised.
c) Consulting NCAS where appropriate.

d) Considering whether measures for exclusion from or restrictions in practice are required.
e) Informing the medical or dental practitioner of the concerns.
f) Ensuring that, at all times, concerns about the conduct, capability or health of doctors and dentists are appropriately and objectively assessed, investigated and, if necessary, appropriate action is taken to protect staff, the population and PHE's reputation.

4.6 The HR directorate will:

(a) Advise senior and line managers about this policy and procedure.
(b) Advise on the use of the procedure and help to maintain consistency of approach in dealing with conduct, capability and health matters.
(c) Attend formal meetings and hearings when required.
(d) Make arrangements for hearings and appeals when required, in line with Appendix 1 of this policy.
(e) Monitor the conduct of cases to ensure consistency.

5. EQUALITY ANALYSIS

5.1 The duties of PHE, both in its mission to reduce inequalities and as an employer under the Equalities Act, have been considered in the production of this policy. The outcomes of this policy may be subject to an Equality Analysis to maintain its effectiveness.

6. ASSOCIATED POLICIES AND STANDARDS

6.1 Due to the diverse nature of poor performance line managers should make themselves familiar and consider the following associated policies:-

- PHE Code of Conduct for staff
- PHE People Charter
- Bullying and harassment policy
- Grievance Policy
- General Medical Council Good Medical Practice
- General Dental Council Standards for the dental team.

6.2 All of the PHE policies, as well as the relevant sets of guidance notes that support this policy, can be found on the intranet:-

- Identifying conduct, capability or health concerns about doctors and dentists in PHE
- Supporting doctors and dentists with conduct, capability or health concerns in PHE
- Preparing for investigations of concerns relating to conduct, capability or health about doctors and dentists in PHE
- Remediating and developing doctors and dentists in PHE.

Appendix A

Managing Concerns about doctors and dentists in PHE

TABLE OF CONTENTS

PART 1 GENERAL INTRODUCTION

1 INTRODUCTION

1.1 This appendix to the Policy describes the procedure for considering and investigating conduct, capability or health concerns under the Policy. This Appendix complies with the requirements of regulation 10 of The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013) in relation to establishing and implementing procedures to investigate concerns. It should be read in conjunction with the main body of the Policy - **Responding to and managing concerns - Addressing concerns about doctors and dentists in PHE** and accompanying supporting guidance notes, especially in the initial stages, when trying to determine if the matter under consideration is a performance issue. Please see supporting guidance notes - **Identifying conduct, capability and health concerns about doctors and dentists in PHE.**

1.2 In order to comply with Maintaining High Professional Standards in the NHS (HSC 2003/12), which applies to Public Health England (PHE) employed medical and dental staff, PHE has put in place these Appendices to the Policy. These Appendices set out the procedure which applies to all doctors and dentists (referred to as the "practitioners") employed by PHE including locums.

This Appendix provides advice on the following:-

1. Dealing with initial concerns about practitioners
2. Exclusions or restrictions on practice
3. Procedures for investigations
4. Conduct
5. Capability
6. Health

1.3 PHE, recognising the honesty and integrity of its staff, believes that personal and professional conduct should be largely self-regulated. However, PHE accepts that breaches of the rules of conduct and standards of performance will occur from time to time. PHE expects to deal with these breaches firmly but with sensitivity. Breaches should, wherever appropriate, be dealt with locally in the first instance. A number of mechanisms exist for potential problems to be addressed by the medical and dental profession at an early stage on a colleague-to-colleague basis. Please refer to the supporting guidance notes – **Identifying conduct, capability or health concerns about doctors and dentists in PHE.**

1.4 Where formal disciplinary action is used, it should emphasise and encourage improved standards of performance/conduct. It is not a means of punishment. Practitioners who are subject to the procedures in this document will be provided with a summary of rights **(see Appendix B)**.

1.5 Practitioners have the right to be represented and/or accompanied by an accredited representative of a trade union or a workplace colleague. It is a principle of these procedures that where appropriate, issues are dealt with, particularly in the initial stages, by the immediate line manager of the practitioner.

1.6 It is recognised that it may be appropriate on occasions, after consideration by the Responsible Officer and Medical Director, Chief People Officer or Chief Executive to inform the General Medical Council (GMC), General Dental Council, National Clinical Assessment Service (NCAS) and other outside agencies about issues dealt with under these procedures. If a decision is made to make a referral to the relevant regulator the

practitioner will be informed in writing at the same time the referral is made. All correspondence with the these bodies will be copied to the practitioner.

1.7 These Appendices apply to all medical and dental staff employed by PHE, medical and dental staff that hold honorary contracts with PHE and undergraduates on work placements will also be subject to these procedures. Where disciplinary action is contemplated, and the issues relate to a doctor or dentist in training, then the Responsible Officer and Medical Director will inform the training co-ordinator and the relevant Postgraduate Dean (Health Education England). Where, an issue is referred to the Responsible Officer and Medical Director, Chief People Officer or Chief Executive or their nominated deputies, it is understood that the Responsible Officer and the Medical Director or their nominated deputy has the responsibility for making the **final decision** after seeking advice.

2. VALUES AND BEHAVIOURS

2.1 PHE recognises the importance of embedding the PHE's Code of Conduct (which incorporates the Civil Service Code) and in particular the visions and values of PHE. All practitioners will be expected to uphold its visions and values.
The values and behaviours will form an essential part of our culture and will be integrated into all aspects of our work and policies, including recruitment and selection, appraisals, job descriptions and employment policies and procedures including general team responsibilities and communications with colleagues.

2.2 This policy should be read with reference to the PHE People Charter which outlines the values and behaviours expected of all PHE staff and underpins how all PHE policies should be applied.

3. LOCAL MANAGEMENT AND RESOLUTION

3.1 As a general principle, it is expected that the immediate line manager of the practitioner in consultation with appropriate senior management for example, the Service lead, Centre Director or Regional Director (where the Regional Director is not directly involved) will deal with issues of minor misconduct or performance without resort to the Responsible Officer and Medical Director. In such circumstances, it may or may not be appropriate for the Responsible Officer and Medical Director to be informed of the outcome. Please see supporting guidance notes - **Identifying conduct, capability or health concerns about doctors and dentists in PHE.**

3.2 Where appropriate, every effort should be made to resolve the issue through local management action and in a timely manner. Any matter involving potential risk to patient or population safety or reputational risk to the organisation should always be escalated immediately to the Chief Executive / Medical Director and Office of the Responsible Officer for further advice.

4. RIGHT TO BE ACCOMPANIED

4.1 Any practitioner covered by this policy and procedures may be represented by a friend, partner/spouse, work colleague or trade union/defence organisation representative. The companion/representative may be legally qualified but they will **not be acting in a legal capacity**. This means it is impermissible for a lawyer, either a solicitor or a barrister, to advise as a "friend" on **any kind of remunerated basis**. If there is any doubt as to who a practitioner may or may not bring along as a companion, this should be raised with the Case Manager responsible for the case. The right to be accompanied extends to any of

the meetings or hearings referred to throughout the policy and procedures. It is important to note that a disciplinary hearing is not equivalent to a legal court of justice, but that a practitioner may seek advice on the appropriateness of legal representation[1]. **See Appendix B**.

5. EQUAL OPPORTUNITIES

5.1 All managers and directors (whether internal or external to PHE) who are involved in undertaking investigations or sitting on disciplinary/capability panels or appeal panels shall have undertaken formal equal opportunities training prior to undertaking such duties. Case Managers, Case Investigators and panel members shall be trained in the operation of the disciplinary and capability procedures.

6. THE NATIONAL CLINICAL ASSESSMENT SERVICE ("NCAS")

6.1 There are a number of references within this procedure to NCAS. Where the involvement of NCAS is appropriate they should be consulted at an early stage in the relevant procedure.

NCAS can be contacted at:

NHS Litigation Authority
2nd Floor, 151 Buckingham Palace Road London SW1W 9SZ.
General enquiries: 020 7811 2600 | Fax: 020 7931 7571.

NCAS core office hours are 9.00am to 5.00pm, Monday to Friday.

Contact numbers are:

NCAS England: 020 7811 2600 (**new number from 21 March 2016)**

NCAS Northern Ireland: 028 90 690 791 **(new number)**

NCAS Wales: 029 2044 7540

Out of hours, you can request a call online.

7. DOCUMENTATION

7.1 At all times it is critical that the steps taken under this process are properly documented and stored in confidential files with restricted access and in full accordance with PHE's information security polices and processes.

8. THE DUTY TO PROTECT PATIENTS AND THE GENERAL PUBLIC

8.1 The duty to protect patients, population and the reputation and trust of the organisation is paramount in the application of this procedure.

[1] http://www.hrlaw.co.uk/site/infobank/infobank_litigation/legal_representatation_at_disciplinary_hearings

9. THE DUTY TO CO-OPERATE

9.1 It is recognised that it is in the interests of both any affected practitioner and PHE to ensure the procedures set out in this document are carried out efficiently and without unnecessary delay. Both parties will co-operate at all times to ensure that this occurs.

10. KEY PERSONNEL

10.1 Under these guidelines a number of key PHE individuals may need to be involved. They are:

- the Chief Executive
- the Responsible Officer (or nominated deputy)
- the Medical Director (or nominated deputy)
- a Case Manager
- a Case Investigator
- the External Independent Person
- the Chief People Officer
- the HR business partner
- a Clinical Adviser or consultant in the relevant specialty
- a Training Coordinator
- the Centre Director
- the Service Area Lead

10.2 See the definitions of confirmation of these individuals' roles and responsibilities in **Appendix C**.

PART 2 INITIAL STEPS WHEN A CONCERN IS RAISED

1. RAISING CONCERNS ABOUT A PRACTITIONER

1. All **serious** concerns must be registered with the Chief Executive. If an employee has a concern about the conduct or capability of a practitioner or an external person or organisation or relative raise a concern with an employee, he/she should immediately report it to his/her Line Manager. It is for the Line Manager to urgently notify the concern through the appropriate management line to the Chief Executive, Responsible Officer or Medical Director. More information on what constitutes a serious concern can be found in the accompanying guidance notes "Identifying conduct, capability and health concerns in doctors and dentists in PHE. Efforts should be made to resolve less serious concerns through local management in the first instance.

1.2 Common sense needs to be applied to determine whether such concerns are of sufficient substance that they need to be reported. If a Line Manager is in any doubt, he/she should err on the side of caution and report it via management to the Chief Executive, Responsible Officer or Medical Director. If necessary, the Line Manager may consult with the Chief People Officer prior to notifying the Chief Executive. Further information can be found in the guidance notes **Identifying conduct, capability or health concerns about doctors and dentists in PHE**.

2. APPOINTMENT OF A CASE MANAGER

2.1 Once a **serious** concern of substance has been raised with the Chief Executive, Responsible Officer and Medical Director he/she must ensure that a suitable Case Manager is appointed. Case Managers must be appropriately trained in this role and can include the Responsible Officer, Medical Director or nominated deputy (nominated deputies include all Directors) where the concern relates to all consultant medical and dental staff. Where the concern relates to a practitioner who is not a consultant, the Responsible Officer and Medical Director may designate an appropriate nominee as Case Manager. In either case a proposed Case Manager will be "inappropriate" in the event that he/she has had prior substantive involvement in the issue or issues of concern that have arisen. In such a case another appropriately selected individual from within PHE or another employer will be nominated by the Chief Executive.

2.2 If concerns relate to a doctor or dentist in training the Training Coordinator will be notified and a way forward agreed in conjunction with Health Education England.

3. APPOINTMENT OF THE EXTERNAL INDEPENDENT PERSON

3.1 The Chief Executive (delegated to the Chief People Officer) will ensure that an External Independent Person is appointed to oversee the process and ensure momentum is maintained throughout the formal investigation. This individual will have any other contractual relationship with PHE, and will not be a practitioner connected to PHE for the purposes of revalidation. The role of the External Independent Person is to ensure that the investigation proceeds at a reasonable rate and that due process is followed.

4. CONFIDENTIALITY

4.1 Confidentiality should be maintained at all times both within and outside of the organisation. PHE or the practitioner must not issue a press statement. The name of the practitioner will not be released by PHE.

5. RESTRICTIONS ON PRACTICE OR EXCLUSIONS

5.1 When a concern is raised the possibility of restrictions on practice or exclusions must be considered. This decision will be taken by the Chief Executive and/or Case Manager dependent on the nature and severity of the concern in question. In implementing any decision on restrictions or exclusions, the provisions of Part 3 of this guidance will need to be followed.

6. THE CASE MANAGER'S INITIAL ASSESSMENT

6.1 The Case Manager should carry out a preliminary assessment to establish the nature and seriousness of the concern. The assessment is based on the information available at the time and the likelihood that the concern can be resolved through local management or whether it will be necessary to appoint a Case Investigator to carry out a full investigation. An initial telephone conversation with the practitioner involved is an essential part of this process unless there are exceptional circumstances that make this impossible. This initial assessment may include short interviews with key witnesses and review of any documents relevant to the concern raised. The Case Manager should seek guidance from the Chief People Officer, Responsible Officer and Medical Director (if he/she is not the Case Manager) and NCAS **(see Appendices C and D)**.

6.2 Except in cases where the Case Manager decides it is necessary to exclude the practitioner immediately or where the initial evidence clearly exonerates the practitioner he/she should set out his or her views on how the matter should be taken forward, in a brief report "The Initial Assessment Report". Guidance on the format and required content for the Case Manager's report is at **Appendix G**.

7. THE CASE MANAGER'S RECOMMENDATIONS

7.1 Local management and **resolution**

If the Case Manager considers a local approach should be taken to address the problem, he/she must indicate the nature of the proposed approach and the personnel who may be involved, where possible in agreement with the practitioner concerned. Where a local route is chosen, NCAS can still be involved until the problem is resolved. This can include NCAS undertaking a formal clinical performance or behavioural assessment when the practitioner, PHE and NCAS agree this could helpful in identifying the underlying causes of the problem and any possible remedial steps. See guidance notes – **Remediation and rehabilitation of doctors and dentists in PHE.**

7.2 **If serious concerns are raised**

If a **serious** concern has been raised, the Case Manager must again consider whether restrictions on or exclusion from practice are appropriate **(see Part 3)**. The Case Manager will then have to decide whether or not the issues raise serious concerns that put clinical service and public safety at risk. The Case Manager must make this decision within 5 working days**.**

7.3 **Less serious concerns**

If the matter is less **serious** a formal investigation involving a Case Investigator may be initiated. If the doctor admits all the issues and there is good evidence presented that clearly identifies the matters then it may be appropriate to consider whether an alternative approach may be made through the seeking of NCAS advice. This then could result in the application for an NCAS assessment for the practitioner or a remediation plan to be put into place as an alternative.

7.4 **Timescale for the Case Manager's recommendations**

There will be situations where it is necessary to immediately exclude a practitioner or restrict his/her practice. The Case Manager must consider this first. Where immediate action is not required, the question of what further steps should be taken remains. The Case Manager should aim where possible to reach a decision as to his/her recommended action to the Responsible Officer and Medical Director or, if the Responsible Officer or Medical Director is the Case Manager, to the Chief Executive, within **5 working days** of the concern being reported to him/her and after any attempt at local resolution has been discontinued.

8. ACTION IN THE EVENT THAT MINOR SHORTCOMINGS ARE IDENTIFIED

8.1 **Counselling**

Minor shortcomings shall initially be dealt with locally. The practitioner's Line Manager will be responsible for discussing the shortcomings with a view to identifying the causes and offering help to the practitioner to rectify them. Such counselling will not in itself represent part of the disciplinary procedure.

8.2 **Oral reprimand**

In the case of minor lapses in performance, the Line Manager may give an oral reprimand without a formal disciplinary investigation or hearing for the purpose of improving future performance and behaviour, and in order to assist the practitioner to meet the standards required. The reprimand should be confirmed in writing to the practitioner. Further advice and guidance on identifying and managing minor shortcomings is available from Human Resources. This is not a formal disciplinary sanction. Further information can also be found in the guidance notes – **Identifying conduct, capability or health concerns about doctors and dentists in PHE.**

8.3 **Situations in which ill health was a contributing factor**

In situations where a person's ill health is a significant contributory factor to their conduct or performance then separate procedures for dealing with ill health and capability would be used. (Further guidance can be obtained from the Capability Procedure at Part 5 below). Consideration should be made to a referral of the practitioner to the Occupational Health services and the Employee Assistance Programme. Further information is available within the guidance notes - **Supporting doctors and dentists with conduct capability or health concerns in PHE.**

8.4 **Action in the event of a pattern of behaviour**

If a particular pattern of inappropriate behaviour/sub-standard performance has been identified, managers are referred to the assessment tool in Guidance Notes 1: Identifying conduct, capability and health concerns in doctors and dentists in PHE for further information ono how to take this into account. Any new, unrelated shortcomings arising during a counselling or review period may be identified, and acknowledged as a separate issue but may be reviewed concurrently.

9. ACTION IN THE EVENT THAT SERIOUS SHORTCOMINGS ARE IDENTIFIED

9.1 **Appointment of a Case Investigator**

If the Case Manager considers a formal investigation is needed, the Responsible Officer and Medical Director or, if the Medical Director is the Case Manager, in discussion with the Chief Executive and the Chief People Officer, shall decide whether to appoint a Case Investigator. If the Case Investigator is from a significantly different area of practice or a non-clinician, a Clinical Advisor from the same speciality as the practitioner under consideration should be involved. The Clinical Advisor should not have been involved in the issue being investigated.

9.2 **Terms of reference**

When a Case Investigator is appointed, the terms of reference for the investigation should be determined by the Case Manager, usually in consultation with the Chief People Officer. Guidance on the terms of reference is set out at **Appendix H**.

9.3 **Informing the Practitioner**

As promptly as possible after the decision to carry out a formal investigation is taken (which should generally be no later than **five working days** after the Case Manager's Initial Assessment Report has been finalised), the practitioner should be notified in writing of:

- The fact that an investigation is to be carried out;
- The specific allegations or concerns;
- The name of the Case Investigator and where relevant any clinical adviser;
- If known, the list of people to be interviewed by the Case Investigator;
- The practitioner's right to meet the Case Investigator to put his/her views;
- His/her right to be accompanied (see Part 1).

The practitioner also has the right to see any relevant documentation relating to the investigation including all written statements available at that time prior to submission of his/her final statement. Guidance on this letter can be found at **Appendix I**

9.4 **Meeting with the practitioner**

The Case Manager and the Chief People Officer (or nominated deputies) will meet with the practitioner either face to face or by teleconference to discuss the investigation process with the individual and to go through the terms of reference. The practitioner will be able to bring forward any further relevant information at that meeting for the Case Manager to consider and any changes in the terms of reference made. The Case Manager may also need to consider whether third parties may need to be informed about any relevant further information being presented by the practitioner. The practitioner has the right to be accompanied to this meeting by a supporter whose name should be made known to the Case Manager in advance of the meeting and who cannot be a solicitor or barrister acting in a legal capacity.

PART 3 CARRYING OUT AN INVESTIGATION

1. Time limit for carrying out the investigation

The Case Investigator should usually complete their investigation within **three months** of his/her appointment **unless and extension has been agreed with the Case Manager,** and submit the draft report to the practitioner for factual comment within a further **10 working days**. In circumstances where a Case Investigator cannot meet the 10-week target, he/she should, as soon as this is realised, notify in writing **BOTH** the Case Manager and the practitioner in question explaining the reasons why. A revised timetable should be provided in addition to an explanation. This information should also be supplied to the practitioner's Line Manager by the Case Investigator.

2. Procedure for carrying out the investigation

The Case Investigator has wide discretion in how he/she carries out the investigation so long as he/she establishes the facts in an unbiased way and adheres to the terms of reference. If the Case Investigator is a non-clinician, a Clinical Advisor should be involved where clinical issues arise. The Clinical Advisor should not have been previously involved in the issue being investigated. The Case Investigator should seek assistance from the Chief People Officer or a senior member of the Chief People Officerate where appropriate. Where the concerns relate to a serious complaint from a patient or colleague the Case Investigator should liaise with the identified communication manager to agree the approach to be taken. PHE is committed to the resolution of any complaint. Reference should be made to PHE's complaints procedure for added information.

3. Action in the event that new issues arise during the course of the investigation

In the event that new issues of concern arise during the investigation, the Case Investigator will inform the Case Manager in writing of the nature of the new issues that have arisen and supply the supporting evidence. The Case Manager, in consultation with the Chief People Officer, will decide whether to amend the terms of reference to cover the new issues of concern. In the event that the terms of reference are to be varied, the Practitioner will be provided with the amended terms of reference in the form set out at **Appendix G** above, together with an explanation of the change. The time limit for completion may be reviewed to take into consideration the time required to explore the new issues. The Case Investigator should, however, still strive to complete their investigation within four weeks of the terms of reference being amended.

4. THE CASE INVESTIGATOR'S REPORT

4.1 **The content of the Case Investigator's Report**

Once the investigation has been completed the Case Investigator must prepare his/her written report, with the Clinical Advisor's assistance if necessary. Guidance on the content and format of the report is at **Appendix I**. The report should provide the Case Manager with enough information to decide whether:

- there is a case of misconduct to put to a conduct panel **(see Part 5)**;
- there are concerns about the practitioner's health to be considered by the Occupational Health department **(see Part 7)**;
- there are performance concerns to be further explored with the NCAS;
- restrictions on practice or exclusion from work need to be considered **(see Part 4)**;
- the concerns should be referred to the General Medical Council ("GMC") or General Dental Council ("GDC");

- the matter should be dealt with under the capability procedures **(see Part 6)**; or
- No further action is needed.

4.2 **The right of the practitioner to comment on the factual parts of the report**

Before a final report into concerns about conduct, capability or health is provided to the Case Manager, the Case Investigator must provide the factual parts of his/her report to the practitioner for comment. The practitioner has **10 working days** in which to comment on the report unless an alternative timescale is agreed in writing with the Case Manager as requested by the Case Investigator. If the practitioner (or his/her representative) fails to provide his or her comments within the **10 working day** time limit or such other time limit as may be agreed with him/her, the Case Investigator will finalise his/her report, recording the fact that it has not been possible to obtain the practitioner's comments.

4.3 **Decision of the Case Manager**

Once the report is completed it must be provided to the Case Manager who will then decide which course of action set out in 4.1 needs to be taken. If the Case manager decides that a Decision Making Group is to be convened, this should meet within **10 working days** of the receipt of the final report. If the Case manager decides that a Decision Making Group is not required, (s)he should decide the course of action within 5 working days of receipt of the final investigation report. The Case Manager should discuss the report with the Chief Executive as well as with the NCAS, if necessary. The Case Manager will write to the practitioner enclosing a copy of the report together with the statements and other evidence gathered in the course of the investigation. The letter will set out the Case Manager's decision and the reasons for it. (**See Part 5**, paragraph 3 in relation to capability procedure). It should be noted that evidence obtained during the course of the investigation may clearly exonerate the practitioner and provide a sound basis for the effective resolution of the matter. When this occurs, the practitioner should be informed immediately.

5. OVERSIGHT OF THE INVESTIGATORY PROCESS

5.1 The Office of the Responsible Officer will retain oversight of the investigatory process, ensuring that there is consistency in all investigations and that investigations are completed in a timely fashion.

PART 4 EXCLUSIONS OR RESTRICTIONS ON PRACTICE

1. INTRODUCTION

1.1 Under this procedure a practitioner is not suspended: he/she can only be excluded from work. The word suspension should not be used when dealing with a practitioner. Exclusion is a last resort and can only be justified on the grounds set out below as whilst it is a neutral act, it is often distressing for the practitioner. Before the decision is taken to exclude any practitioner, all other options must have been thoroughly explored, for example:

- Supervision by the Responsible Officer or Medical Director or their nominated deputy of normal contractual duties.
- Restricting a practitioner's duties to certain duties.
- Restricting a practitioner to administrative, research/audit and teaching duties.
- Sick leave for specific health problems.

2. ROLES OF OFFICERS

2.1 Power to exclude or restrict a Practitioner

The Chief Executive has overall responsibility for managing exclusions and restrictions.
A decision to exclude or restrict a practitioner can only be made by:

- the Chief Executive (or anyone acting in that capacity);
- the Responsible Officer (or anyone acting in that capacity);
- the Medical Director (or anyone acting in that capacity);
- the Chief People Officer (or anyone acting in that capacity);

2.2 Responsibilities of individual officers in the event of a restriction or exclusion

2.2.1 The Case Manager

It will usually be for the Case Manager to make the initial recommendation to one of the individuals shown in 2.1 whether to exclude or restrict a practitioner. However there may be circumstances where this may not be possible in which case the officers listed in paragraph 2.1 will be empowered to make this decision. A decision to exclude a practitioner will only be made once it has been decided that there are significant concerns about the practitioner's conduct or capability and the conditions set out in paragraph 4 below have been satisfied. The Case Manager will review the exclusion or restriction with the External Independent Person and Chief Executive as set out below, taking into consideration any information that may be provided to him/her by the Case Investigator.

2.2.2 The External Independent Person

The External Independent Person shall oversee the exclusion or restriction process. This role will include ensuring that the applicable time limits are complied with, as well as receiving representations on the process or procedure leading to the exclusion or restriction.

2.2.3 The Case Investigator

The Case Investigator shall from time to time provide such information to the Case Manager as may be relevant to the review of the decision to exclude or restrict the practitioner.

3. THE RESTRICTIONS THAT CAN BE IMPOSED ON THE PRACTITIONER

If a serious concern is raised about a practitioner, the Case Manager must consider at the outset if temporary restrictions on the practitioner's practice are necessary. There are four options for restriction:

- Obtaining voluntary undertakings from the practitioner on what he/she will and will not do;
- Placing the practitioner under the supervision of the Responsible Officer or the Medical Director or a nominated deputy;
- Amending or restricting clinical duties; and
- Restriction to non-medical duties.

If there is evidence that concerns are related to the practitioner's health, the Occupational Health Department should become involved at an early stage to help with the investigation of specific health problems and to advise the Case Investigator accordingly **(see Part 6)**. The practitioner's Line Manager should also be notified.

A practitioner who has been excluded must still have access to the documentation necessary for him/her to prepare for the investigation. If there are justifiable concerns that the practitioner might seek to tamper with evidence, either all access should be directly supervised or copies made available.

4. WHERE EXCLUSION MAY BE JUSTIFIED

4.1 Exclusion is a temporary measure reserved for specific circumstances and does not imply guilt. Alternatives to exclusion must always be considered in the first instance. Exclusion is only potentially justified where:

- There has been a critical incident where serious allegations have been made; or
- There has been a breakdown in relationships between a colleague and the rest of the team; or
- The presence of the practitioner is likely to hinder the formal investigation.

4.2 The key factors in any decision to exclude are:-

- the protection of staff or clinical service safety interests; or
- to assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

5. THE PROCESS FOR DECIDING WHETHER TO EXCLUDE OR RESTRICT

5.1 There are two types of exclusion: immediate exclusion dealt with in paragraph 6 below, and formal exclusions which are dealt with under paragraph 7. In addition, restrictions of practice may be imposed. Before reaching the decision to exclude, it is important to seek the NCAS's assistance. However, ultimately the decision on restriction(s) or exclusion rests with PHE's authorised officers as set out in paragraph 2.1. Where the officers of PHE disagree with the NCAS, the reasons for this divergence in view should be carefully recorded in writing.

5.2 Any decision to exclude formally should be discussed with the Chief Executive and the Chief People Officer. The External Independent Person should be informed of any such decision. A decision to exclude immediately should, where practicable, follow the same procedure, although, in the event that this is not practicable, the officer designated under paragraph 2.1 shall discuss the decision as soon as practicable with the Chief Executive and Chief People Officer, and confirm that decision to the External Independent Person.

6. IMMEDIATE EXCLUSION

6.1 The right to exclude immediately

In a circumstance referred to in paragraph 4 above, where no alternative is deemed appropriate by the officers listed at paragraph 2.1, the practitioner may be excluded immediately to allow preliminary consideration of the concern by the Case Manager and Case Investigator.

6.2 The initial period of immediate exclusion

An immediate exclusion can be for a **maximum of two weeks** following which a decision whether to exclude formally must be made in accordance with the procedure set out in paragraph 7 below. If the decision is to restrict a practitioner's practice, it should also be reviewed, though it is recommended this happens when the Case Investigator has completed his/her report.

6.3 Meeting with the practitioner

The practitioner should be informed at a meeting that they are being excluded immediately, together with the broad reasons for the exclusion. A date should be agreed to meet again within the two weeks commencing on the date of the exclusion. The practitioner should be reminded of their right to representation. The meeting should be immediately followed by a letter confirming the outcome of that meeting. **Appendix E** is a form to be completed on making an initial assessment of what measures to take. **Appendix F** is a template letter to send to a practitioner in these circumstances.

7. FORMAL DECISIONS TO EXCLUDE OR RESTRICT PRACTICE

7.1 The right to exclude formally

A formal exclusion can only take place after:

- A preliminary report has been prepared by the Case Investigator which confirms there is misconduct/capability concern or further investigation is warranted;
- The Case Manager, if possible, provisionally assesses whether there is a case to answer;
- A meeting has been held with the practitioner in accordance with paragraph 7.4; and
- The NCAS has been consulted.

7.2 Justification of the decision to exclude formally

Formal exclusion can only be justified where there is a need to protect population and/or clinical service or staff interests pending the full investigation of:

- Allegations of misconduct;
- Concerns about serious dysfunction in the operation of services;
- Concerns about lack of capability or under performance; or
- Where the practitioner's presence is likely to hinder on-going investigations.

Other options such as restrictions of practice must be considered. Exclusion is to be used only where it is strictly necessary for the reasons set out above.

7.3 Considerations in a decision to exclude formally

The checklist set out at **Appendix J** should be completed where considering a formal exclusion/restriction.

7.4 Meeting with the practitioner

The practitioner should be informed of the exclusion in a meeting with the Responsible Officer or Medical Director and/or the Case Manager. A Human Resources Manager should be present at this meeting where possible. The reasons for the exclusion must be

explained and the practitioner shall have an opportunity to respond and suggest alternatives to exclusion.

7.5 Confirming formal exclusion in writing

Formal exclusion must be confirmed in writing to the practitioner within **five working** days, where practicable, of the decision being taken. This letter must state:

- the duration of the exclusion;
- the nature of the allegations being made;
- the terms of the exclusion;
- a full investigation or other action will follow; and
- the External Independent Person may receive any representation on the exclusion. (**See Appendix F –** Template letter to send to a practitioner in these circumstances).

A formal exclusion can last for a maximum of **four weeks** at which point it must be reviewed (see paragraph 12 below).

8. EXCLUSION FROM PHE PREMISES

8.1 A Case Manager must decide if exclusion from PHE premises is necessary as exclusion may not necessarily involve the need for an exclusion from all PHE premises. An exclusion from PHE premises is necessary where there is a risk the practitioner will tamper with evidence or seek to influence colleagues. Population and/or clinical service safety must come first; if there is a risk of disruption to clinical services by the practitioner's presence, he/she should not be allowed onto PHE premises. Where possible, an excluded practitioner should be allowed on PHE premises for continuing professional development purposes.

8.2 As an alternative to complete exclusion from PHE premises, the Case Manager may consider a limited exclusion from certain parts of PHE premises. In the event that such exclusion is put in place but then breached by the practitioner, a full exclusion may be substituted.

8.3 Exclusion from duties also includes restriction to all PHE electronic files and emails. Excluded practitioners would be expected to return any laptops or other PHE provided communication equipment once exclusion has been authorised.

9. PRACTITIONER'S DUTIES IF EXCLUDED

9.1 An excluded practitioner must be ready, willing and able to carry out some or all of his/her duties during contractual hours as agreed with their Line Manager. He/she must be available to assist the Case Investigator during these hours. He/she must obtain permission to take annual or study leave from the Case Manager.

10. OBLIGATIONS ON THE PRACTITIONER IN THE EVENT THAT EXCLUSION IS CONSIDERED

10.1 Duty to co-operate

A practitioner should co-operate with PHE in finding alternatives to exclusion by:

- agreeing to restrictions on his/her practice, including a restriction to non-clinical duties;
- agreeing to not interfere with investigations involving him/her;
- agreeing to give undertakings not to carry out certain work. The NCAS may recommend such undertakings extend beyond PHE to the public and private sector;
- agreeing to work under supervision.

10.2 Duty on the practitioner to provide information

An excluded practitioner must notify the Case Manager of any other organisations for which they undertake voluntary or paid work during the period of exclusion. The practitioner must seek prior consent from the Case Manager to continue to undertake such work if appropriate. The Case Manager should discuss with the Responsible Officer or Medical Director as appropriate to consider whether information should be passed on to any other relevant employer of the practitioner on a need to know basis.

10.3 Duty to provide written commitments

A practitioner should be prepared to give any of these commitments in writing to ensure there is no confusion about them. If a practitioner refuses to give any such commitments, a Case Manager can legitimately take this into account when deciding whether to exclude or not.

11. CONSEQUENCES OF NON COMPLIANCE WITH THE PRACTITIONER'S DUTIES

11.1 In the event the practitioner fails to comply with his or her duties under paragraphs 9 and 10 above, he/she may be subject to disciplinary action on the grounds of failure to comply with a reasonable management instruction.

12. REVIEWING EXCLUSIONS AND THE ROLE OF THE EXTERNAL INDEPENDENT PERSON

12.1 First Review

The Case Manager must initially review the practitioner's formal exclusion before the expiry of four weeks from the decision to exclude and:

- submit a written advisory report of the outcome of that review to the Chief Executive/ External Independent Person;
- document the renewal;
- send written notification of the renewal to the practitioner.

Any change of circumstances since the original decision to suspend must be addressed by the Case Manager in his/her written review report. This review report should be provided to the practitioner under investigation to the Chief Executive and the External Independent Person.

12.2 Second Review (and reviews after the Third Review)

Before expiry of a further four weeks from the date of the previous review, the Case Manager must review the exclusion and follow the steps detailed under the First Review above.

12.3 Third Review

If exclusion continues for a further four weeks from the Second Review, a Third Review should be carried out.

If an investigation has been completed showing there is a case to answer, prompt steps need to be taken to set up the appropriate hearing to consider the case.

If a practitioner has been excluded for three periods and the investigation has not been completed, the Case Manager must:

- Submit a written report to the Chief Executive including:
- the reasons for the continued exclusion;
- evidence to explain why less onerous restrictions on practice are not appropriate;
- the timetable for completing the investigation.

- Formally refer the matter to the NCAS confirming:

- why exclusion remains appropriate; and

- the steps taken to conclude the exclusion.

The Chief Executive must inform the External Independent Person of:
- the action proposed to resolve the situation;
- the reason for the continued exclusion;

The NCAS will review the case and advise PHE on handling the case.

12.4 Six Month Review

Exclusions should not normally last for more than **six months** unless a criminal investigation is ongoing. If it does a report must be prepared by the Chief Executive for the Department of Health setting out:
- the reasons for continuing the exclusion;
- anticipated timescale for completion of the process.

13. ROLE OF THE EXTERNAL INDEPENDENT PERSON

13.1 PHE's responsibility, having been informed via the External Independent Person is to ensure the procedures set out above are followed but no more. PHE will add as a standing agenda item for the closed part of PHE Management Committee meetings a review of excluded/restricted practitioners. The External Independent Person should assess if proper progress is being made with investigations and that those people who should be involved are involved. The Case Manager should have a monthly statistical report prepared for the External Independent Person showing all exclusions, their duration and the number of times they have been reviewed or renewed.

14. POLICE INVOLVEMENT

14.1 Where any allegations give rise to potential criminal allegations the Chief People Officer should be consulted at the earliest opportunity. Police investigations are not necessarily a bar to continued internal investigations. However, if the Police do not consent to PHE continuing with an investigation, PHE must cease that investigation.

15. REPORTING MATTERS OUTSIDE PHE

15.1 If a practitioner may represent a risk to patient or population safety, PHE has a duty to notify the public and private sector organisations of this. Where details of other employers are not readily available to PHE, the practitioner is obliged under paragraph 10 to provide this information. Failure to do so may result in disciplinary action as well as possible referral to the GMC/GDC.

16. BREACH OF A RESTRICTION

16.1 Where a restriction has been placed on the practitioner's practice, they shall agree not to undertake any work in that area of practice with any other organisation whether on an employed basis or otherwise and whether in the private or public sectors. If a practitioner breaches an undertaking he/she has given the case manager should consult with the NCAS on whether a Health Professional Alert Notice (HPAN) letter should be issued. Guidance on issuing an alert letter (HPAN) is contained in HSC 2002/011. This breach of an undertaking may also give rise to disciplinary action against the practitioner.

17. REPORTING TO THE GMC OR GDC

17.1 At the point where serious allegations affecting patient or population safety arise, the case manager has a duty to consider reporting the matter to the GMC/GDC. This could be at the stage of immediate exclusion or when the Case Investigator's report has been provided.

18. LIFTING AN EXCLUSION OR RESTRICTION

18.1 If at any point the Case Manager or Chief Executive consider that the exclusion from work or restrictions on practice are no longer appropriate for any reason, then the exclusion or restrictions shall be lifted and the practitioner allowed to return to their duties. This will be confirmed in writing to the practitioner together with the arrangements for the return to work. Appropriate support shall be given to the practitioner to facilitate a return to work. The matter shall also be reported to the External Independent Person.

PART 5 CONDUCT PROCEDURES

1. INTRODUCTION

1.1 At the initial stage set out in paragraph 2, Part 2 the Case Manager should consider whether the concern may amount to an issue of conduct. This may not be a final decision, and the Case Manager should review this decision on receipt of the Case Investigator's report **(paragraph 4, Part 3)**.

1.2 In cases where there are both conduct and capability concerns these are usually heard under the capability procedures. In some circumstances there may be valid reasons for dealing with the different types of concerns separately.

1.2 Any concerns relating to practitioners in training grades must be discussed with the relevant educational supervisor and college or clinical tutor, together with the Training Coordinator at the outset.

2. DEFINITION OF MISCONDUCT

2.1 Examples of misconduct will vary widely but may fall into one of the following broad categories:

- A refusal to comply with reasonable requirements of PHE;
- An infringement of PHE's disciplinary rules including standards of professional behaviour required by the relevant regulatory body;
- Commission of a criminal offence outside the work place resulting in a conviction or a caution;
- Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of population and/or patient care or safety or likely to create serious dysfunction to the effective running of the service;
- A failure to fulfil contractual obligations; or
- Failing to provide proper support to other members of staff.

2.2 The PHE's Code of Conduct represents the minimum level of behaviour required of staff, and is supplemented by the PHE People Charter. Breach of this code may be considered as misconduct. Examples of gross misconduct are included at **Appendix K**. As a general rule a practitioner should not be dismissed for a first offence unless it is one of gross misconduct.

3. INVESTIGATION OF ALLEGATIONS

3.1 Every potentially serious allegation must be fully investigated. Where the alleged misconduct involves matters of a professional nature, the Case Investigator should obtain independent advice from a senior clinician in the same speciality as the practitioner. The investigation process will be carried out in accordance with Part 3 'Carrying out an investigation', paragraph 2.

4. CLASSIFICATION OF THE CONCERNS

4.1 The Case Manager will, on receipt of the Case Investigator's report and having consulted with the NCAS, the Chief People Officer, and the Chief Executive, consider the classification of the concerns about the practitioner.

If the Case Manager concludes that the concern is one of conduct the remainder of this part of this policy section will be followed. If the concern is one of capability, Part 6 should be followed. If the concern is one of health, Part 7 should be followed. The classification will be confirmed to the practitioner in writing in the letter confirming the

outcome of the investigation (see paragraph 4, Part 3) along with the Case Manager's conclusions.

4.2 In some cases there may be elements of all three types of concerns. In cases where there are both conduct and capability concerns these should be considered under the capability procedures as set out in Part 6. In certain circumstances the conduct issues can be pursued separately as decided by the case manager. In cases where health is the prominent issue these should be considered as set out in Part 7.

5. CRIMINAL PROCEEDINGS

5.1 **Action by PHE when investigations identify possible criminal acts**
Where the PHE's investigation finds a suspected criminal act in the UK or abroad, this will be reported to the police. Where the police investigate the allegation, PHE's own investigations should only proceed with the agreement of the police. If the Police do not consent to PHE continuing with an investigation, PHE will accede to this request. In a case of fraud, the NHS Protect will be contacted.

5.2 **Action by PHE in the event that criminal charges are successful**
In a circumstance where criminal charges have been successfully brought against the practitioner, PHE will need to carefully consider whether they render the practitioner unsuitable for further employment. PHE will need to consider the overall circumstances of the conviction and in particular patient and population safety and the trust and reputational risk to the organisation and whether exclusion and further investigation is necessary.

5.3 **Action in the event of acquittal or insufficient evidence**
Where a criminal case is pursued but the practitioner is acquitted or where there was insufficient evidence to take the matter to court, there is a presumption that the practitioner will be re-instated to full duties. PHE must however consider whether there is enough evidence to suggest that there is a threat to patient or population safety and the trust and reputational risk to the organisation. If PHE believes this to be the case, the alleged misconduct should be addressed under these procedures. This is so even though the criminal process resulted in the non-conviction of the practitioner.

6. PREPARATION FOR A CONDUCT HEARING

6.1 **Invitation to Hearing**
Where the Case Manager concludes that the case should be taken to a conduct panel, the Case Manager should write to the practitioner inviting him/her to the disciplinary hearing. This letter should be received by the practitioner at least **10 working days** before the date of the hearing (unless there are exceptional circumstances) to allow sufficient time for him/her to consider their case.

The letter should, where possible, include:

- Clear and complete details of the allegations, including (if not already received) a copy of the investigatory report and any supporting evidence (including witness statements);
- Details of who is attending to present the management case;
- Details of members of the panel;
- Details of any witnesses to be called in support of the management case;
- Confirmation of the practitioner's right to be accompanied (**see Part 1** above);
- Confirmation that disciplinary action may be taken as a result of the meeting.

6.2 Documents and Witnesses

6.2.1 Any documents to which the practitioner and/or his/her representative intend to refer at the hearing (including any statement of case) should be provided to the Case Manager no later than 5 working days prior to the hearing, unless there are exceptional circumstances. The practitioner and/or his/her representative will also be provided with copies of all the documents on which the management case will rely at least 5 working days before the hearing (this shall include any statement of case if one is prepared).

6.2.2 The practitioner or his/her representative and the individual presenting the management case must also confirm the names of any witnesses they intend to call at least 5 working days before the hearing.

6.2.3 Any witness statements to be relied upon by the practitioner must be provided to the Case Manager no less than 5 working days before the hearing. If the practitioner does not intend to rely upon witness evidence but does intend to call a witness in support of his or her case, the practitioner must provide a written synopsis of the relevant evidence the witness will provide. This synopsis must be provided no later than 5 working days before the hearing to the Case Manager.

6.2.4 It is the responsibility of the person(s) calling the witnesses to arrange for their attendance at the hearing. Witnesses will not be required to attend all of the hearing, only the period for which they are required to give evidence. Where witnesses are employees of PHE, reasonable expenses will be paid for attendance at the hearing. Where a synopsis has been provided of a witness' evidence by the practitioner, the practitioner must ensure that the witness attends the hearing to provide their evidence unless that evidence has been explicitly agreed by the Case Manager. Witnesses not employed by PHE are also eligible for reimbursement of reasonable expenses and may be eligible for nominal attendance fees.

6.3 Postponement Requests

The practitioner must take all reasonable steps to attend the hearing. Requests for postponements will be considered by the Chairman of the panel and will be dealt with reasonably taking into account all of the circumstances of the case, including:

- the reason for the request;
- the period that the allegations have been outstanding;
- the period it is anticipated that the practitioner will remain on sickness; absence (the practitioner's ill health will be dealt with in accordance with the procedures at **Part 7**.);
- the future availability of the panel and witnesses.

6.4 **Failure to attend the hearing by the practitioner**

A failure to attend a disciplinary hearing by the practitioner without valid reason may result in the process being carried out in the practitioner's absence.

7. THE DISCIPLINARY HEARING

7.1 **Panel Members**

The disciplinary panel for cases involving conduct will be consistent with will the PHE disciplinary Policy and Procedure, and will consist of the level of manager authorised to make the disciplinary sanctions as set out in **Appendix L and** the Chief People Officer or a senior member of the Human Resources team. Where the misconduct relates to a matter of professional misconduct the panel must include a member who is medically or dentally qualified and is not a current employee of PHE.

7.2 The Hearing Procedure

7.2.1 The Chairman of the panel is responsible for ensuring the hearing is conducted properly and in accordance with PHE's procedure. The practitioner has the right to be accompanied at the hearing under the conditions set out at **Part 1**. The Case Manager may be assisted by the Case Investigator(s) (where they are not appearing as a witness) or a senior member of the Chief People Officerate. At all times during the hearing the panel, its advisors, the practitioner, his/her representative and the Case Manager must be present. Once a witness has given evidence he/she shall leave the hearing.

7.2.2 The procedure for the hearing will be as follows:-

- The Case Manager presents the management case;
- The management witnesses will be called in turn. Each witness will confirm their witness statement and provide any additional information. The Case Manager may ask additional questions;
- The practitioner or their representative may ask questions of the witnesses;
- The panel may question the witness once both sides' representatives have asked questions;
- The Case Manager may then ask further questions to clarify any point that has been raised either by the questions of the practitioner or his representative or from the Panel. The Case Manager will not, however, be able to raise new evidence;
- The Chairman may ask the Case Manager to clarify any issues arising from the management case;
- The practitioner and/or their representative shall present their case and call any witnesses. The above procedure used for the management's witnesses shall be followed;
- The Chairman can request any points of clarification on the practitioner's case;
- The Chairman shall invite the Case Manager to make a short closing statement summarising the key points of the management's case;
- The Chairman shall invite the practitioner or his/her representative to make a short closing statement summarising the key points of their case. Where appropriate, this should include any grounds of mitigation;
- The panel shall retire to consider its decision.

8. DISCIPLINARY ACTION

8.1 **Types of Formal Disciplinary Sanctions**

The following outcomes may apply:

- No Action;
- First stage Warning;
- Second stage Warning;
- Final Written Warning;
- Disciplinary Transfer/Demotion;
- Dismissal.

These disciplinary sanctions are normally followed consecutively but a disciplinary hearing panel may elect to go straight to warnings or dismissal depending on the gravity of the situation.

8.2 **First Stage Warnings**

Where previous counselling/a reprimand has failed to result in the necessary improvement, it may be necessary for a first stage warning to be given and in doing so, the panel hearing the case will emphasise the standard of performance or behaviour

expected in the future with a view to assisting the practitioner. A first stage warning is usually delivered verbally in the first instance, but it will be confirmed in writing.

8.2.1 **Confirmation of the first stage warning**

A first stage warning will be confirmed in writing. The warning will confirm that it is the first stage in the disciplinary process and give details of:

- the complaint;
- the improvement or change in behaviour required;
- any training or support that may be given (if appropriate) and the timescale allowed for this);
- any points of mitigation that were taken into consideration;
- and the right of appeal.

The warning should also inform the practitioner that a more severe sanction may be considered if there is not a satisfactory improvement or change in behaviour or performance in the future.

8.2.2 **Timescale for sending out the first stage warning**

The written confirmation of the first stage warning shall be dispatched to the practitioner within 5 working days of the decision.

8.2.3 **Retention of the first stage warning on the practitioner's personal file and Review**

A copy of the warning should be kept on the practitioner's personal file but should be removed from the file and disregarded for disciplinary purposes after a specified period. That period should not exceed six months.

Before the expiry of the specified period, the behaviour or performance of the practitioner will be reviewed, and the Case Manager will decide whether any further action is necessary. If additional episodes of inappropriate behaviour or substandard performance occur within the specified period, it may be necessary to hold this review meeting sooner than the end of the specified period.

8.3 Second Stage Warnings

8.3.1 **First second stage warning**

Where a first stage warning does not result in improved behaviour or performance, or where the issue is more serious, a formal second stage warning may be appropriate.

8.3.2 Content of the second stage warning

The warning will give details of:

- the complaint;
- the improvement or change in behaviour required;
- any training or support that may be given (if appropriate) and the timescale allowed for this;
- any points of mitigation that were taken into consideration; and
- the right of appeal.

The warning should also inform the practitioner that a final written warning may be considered if there is not a satisfactory improvement or change.

8.3.3 Timescale for confirmation of the second stage warning

The confirmation of the second stage warning shall be dispatched to the practitioner within 5 working days of the decision.

8.3.4 Retention of the second stage warning on the practitioner's personnel file and Review

A copy of the warning should be kept on the practitioner's personal file, but should be removed from the file and disregarded for disciplinary purposes after a specified period. That period should not exceed one year. Before the expiry of the specified period, the behaviour or performance of the practitioner will be reviewed, and the Case Manager will decide whether any further action is necessary. If additional episodes of inappropriate behaviour or substandard performance occur within the specified period, it may be necessary to hold this review meeting sooner than the end of the specified period.

8.4 Final written warning

8.4.1 Where there is a failure to improve or change behaviour or performance during the currency of a prior second stage warning, or where the infringement is sufficiently serious, the practitioner will normally be given a final written warning.

8.4.2 The content of the final written warning

The confirmation of the final written warning should give details of:

- the complaint;
- the reasons for the decision;
- warning to the practitioner that failure to improve performance or modify behaviour may lead to dismissal or to some other action short of dismissal;
- any training or support that may be given (if appropriate) and the timescale allowed for this;
- any points of mitigation that were taken into consideration; and
- refer to the right of appeal.

8.4.3 Timescale for confirmation of the final written warning

Confirmation of the final written warning should be sent out within 5 working days of the decision.

8.4.4 Retention of the final written warning on the practitioner's personnel file and Review

A copy of the final written warning should be kept on the practitioner's personal file but should be removed from the file and disregarded for disciplinary purposes after a specified period. That period should not exceed one year. Before the expiry of the specified period, the behaviour or performance of the practitioner will be reviewed, and the Case Manager will decide whether any further action is necessary. If additional episodes of inappropriate behaviour or substandard performance occur within the specified period, it may be necessary to hold this review meeting sooner than the end of the specified period.

8.5 Demotion/Transfer

8.5.1 If a practitioner has reached the stage where termination of employment would normally be considered, it may be possible to consider alternative action if it is appropriate.

8.5.2 In deciding whether the alternative action is appropriate, mitigating circumstances, including length of service and previous employment history, should be taken into account. The panel hearing the case may, if they consider it appropriate, also take into account the views of the Medical Director, lead clinician for the proposed department receiving the practitioner and the practitioner, before making a decision about any

suitable alternative action. Alternative action may include demotion or transfer to an alternative post.

8.6 Dismissal

- Dismissal will occur where a lesser sanction is not appropriate and must be reasonable in all the circumstances of the case.
- Where there is a continuation of a situation which is already the subject of a final written warning, or where there is gross misconduct, the panel hearing the case may decide that dismissal with/without payment in lieu of notice (as appropriate) is the only appropriate remedy. Dismissal without notice is usually appropriate in cases of gross misconduct. Examples of such situations are set out in **Appendix K**.
- Such action may only be taken by an authorised manager **(See Appendix L)**.
- The period of notice, where applicable, will run from the date of the notification of the disciplinary decision.
- The detailed written reasons for dismissal will be dispatched to the practitioner and his/her representative in the form of a letter within five working days of that decision being taken.

9. APPEALS

A practitioner, who is aggrieved by disciplinary action, including dismissal, has a right to appeal.

9.1 **Purpose of the appeal**

The purpose of the appeal is principally to review the decision taken by the disciplinary panel. The appeal panel will consider whether PHE's appeal procedure has been adhered to and that the disciplinary panel had acted fairly and reasonably having regard to:

- a fair and thorough investigation of the issue;
- whether there was sufficient evidence arising from the investigation or assessment on which to base the decision;
- whether in the circumstances the penalty was fair and reasonable.

The appeal panel may consider new evidence presented by the practitioner and decide whether it would have significantly altered the original decision. The appeal panel may also, of its own volition, call evidence that it thinks may be relevant..

9.2 **Timescale for submitting an appeal**

Any practitioner wishing to appeal the decision of the disciplinary panel must submit an appeal, in writing, to the Chief People Officer. The appeal must be received within 15 working days of the date of the letter to the practitioner which confirmed the disciplinary panel's decision. The appeal letter should state fully the grounds for the appeal.

A failure to submit an appeal within the set time limit will lead to the right to appeal being forfeited. The grounds of appeal will be provided to the Case Manager and the appeal panel.

9.3 **Membership of the appeal panel**

Any individual involved in the original disciplinary action or investigation should not be a member of the appeal panel, although he/she may be present either as a witness or in order to present the management case.

The appeal panel shall comprise of three Directors. The panel will be advised by the Chief People Officer or a Senior HR Advisor appointed by the Chief People Officer. The

appeal panel may rely on specialist advice from a consultant in the same speciality as the practitioner if this is appropriate.

9.4 **Response to the Grounds of Appeal**

If the Case Manager's response to the practitioner's Grounds of Appeal is other than as set out in the written decision of the disciplinary panel, the Case Manager must provide this response, in written form, to the practitioner no later than 5 working days before the appeal hearing.

9.5 **Notice of the appeal date and representation**

The practitioner will be given as much notice as possible of the date of the appeal, and will be entitled to be accompanied (see **Part 1**).

9.6 **Timescale for hearing the appeal**

The appeal hearing shall be held within 25 working days of the appeal being lodged unless this is impracticable. The practitioner and PHE shall co-operate to ensure the hearing can be held as quickly as possible.

9.7 **Procedure at the appeal hearing**

The appeal shall be by way of review and not full re-hearing, subject to the modifications that are set out below:

- all parties will have access to all of the documents from the last hearing, including the statements of the witnesses called;
- The practitioner or his/her representative shall present a statement of all the grounds for the appeal;
- The practitioner or his/her representative shall present any additional evidence/witnesses. If they do so, the Case Manager and panel may ask questions of the witness, or question the evidence;
- The Case Manager and the panel shall be entitled to question the practitioner or his representative on the grounds of appeal;
- The Case Manager shall present the management case in response to the grounds of appeal;
- The practitioner and the panel shall be entitled to question the Case Manager;
- The Case Manager shall present any additional evidence/ witnesses in response to any new evidence from the practitioner or their representative and the panel may ask questions;
- The Case Manager shall sum up the management's case;
- The practitioner or his/her representative shall sum up their case. At this stage a mitigation statement may be made;
- The appeal panel shall retire to make a decision.

9.8 **The decision of the appeal panel**

The appeal panel may:-

- Confirm the original decision of the panel;
- Amend the decision of the panel;
- Order the case to be reheard in its entirety.

9.9 **Timescale for the appeal panel's decision**

The appeal panel's decision and the reasons for it must be confirmed in writing to the practitioner within 5 working days of the appeal hearing. A record of the decision shall be kept on the practitioner's personal file including a statement of the conduct issues, the action taken and the reasons for this. Where the appeal related to the practitioner's dismissal and the original decision was to dismiss, he/she will not be paid from the date of termination notified by the disciplinary panel. If the practitioner is reinstated following

the appeal his/her pay shall be backdated to the date of termination of employment. If the appeal panel decided that the whole case is to be reheard, the practitioner 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 hearing shall be applied.

PART 6 CAPABILITY PROCEDURES

1. INTRODUCTION

1.1 Initial consideration must be given as to whether any failure or concern in relation to a practitioner was due to broader systems or organisational failure. If so, appropriate investigation and remedial action should be taken. If the concerns relate to the capability of an individual practitioner, these should be dealt with under this procedure whether arising from a one-off or series of incident/s. Wherever possible, issues of capability shall be resolved through on-going assessment, retraining and support. If the concerns cannot be resolved routinely by management, the NCAS must be contacted for support and guidance before the matter can be referred to a capability panel. Any concerns relating to practitioners in training grades must be discussed with the relevant educational supervisor and college or clinical tutor, plus with the postgraduate dean from the outset.

2. DEFINITION OF CAPABILITY

2.1 The following are examples of matters which PHE may regard as being concerns about capability (this is a non-exhaustive list):-

- Out of date or incompetent clinical practice (unless this is contrary to clear management requests made previously in which case the issue may be one of misconduct – **see Part 5**);
- Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- Inability to communicate effectively;
- Inappropriate delegation of clinical responsibility;
- Inadequate supervision of delegated clinical tasks; and
- Ineffective clinical team working skills.

2.2 In the event that the capability issue has arisen due to the practitioner's ill health, then the Ill Health Procedure in **Part 7** must be considered.

2.3 In the event of an overlap between issues of conduct **(see Part 5)** 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 Chief People Officer, and the NCAS.

3. PRE-CAPABILITY HEARING PROCESS

3.1 Once the Case Investigator has concluded his/her investigation (**see Part 2**, paragraphs 9 and10) the report will be sent to the Case Manager. The Case Investigator will already have provided the practitioner with the opportunity to comment on the factual sections of the report in accordance with **Part 3**, paragraph 4.2 above.

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

3.3 If it is decided to apply the capability process in this **Part 6**, the options available to the Case Manager for dealing with the matter are:-

- No action is required;
- Retraining or counselling should be undertaken;
- The matter should be referred to the NCAS to deal with the case by way of an assessment panel; or
- Referral to a capability panel for a hearing should be made.

4. PREPARATION FOR CAPABILITY HEARINGS

4.1 **Time Limits**

Where a Case Manager has decided to refer the matter to a capability panel, the following preparatory steps must take place:-

- 20 working days before the hearing the Case Manager will notify the practitioner in writing of the decision to arrange a capability hearing;
- The practitioner 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 his/her right to be accompanied;
- 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 upon 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;
- At least 2 working days before the hearing, the parties must exchange final lists of witnesses they intend to call to the hearing. The Chairperson of the panel can invite the witness to attend where a witness' evidence is in dispute. 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, the witness must provide evidence in person at the hearing unless the synopsis of evidence has been explicitly agreed by the other party;

4.2 **Postponement Requests**

In the event of a postponement request, the Case Manager shall deal with the response and may agree time extensions. If the practitioner 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 practitioner's absence.

4.3 **Panel Members**

The panel for the capability hearing shall consist of at least three people including:-

- A national director of PHE;
- A medical or dental practitioner not employed by PHE (following discussions with the LNC/Medical Staff Committee);
- An independent external person or Senior Manager of PHE.
- The national director will normally act as Chairperson of the panel;
- If the practitioner is a clinical academic, a further panel member may be appointed in accordance with any agreed protocol between PHE and the relevant University;
- The panel must be advised by:
- A senior member of staff from HR.
- A senior clinician in the same speciality as the practitioner from a NHS employer. In the event this clinician cannot advise on the appropriate level of competence then a practitioner from a NHS employer of the same grade as the practitioner in question should be asked to advise.

4.4 The practitioner 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.
Within 5 working days of their notification, the practitioner should raise with the Case Manager any objections to the panel members. The Case Manager in consultation with PHE's Chief People Officer 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 PHE to agree the composition of the panel and only in exceptional circumstances shall the hearing be postponed whilst the matter is resolved.

5. THE CAPABILITY HEARING

5.1 The Chairman of the panel is responsible for ensuring the hearing is conducted properly and in accordance with PHE's procedure. The practitioner has the right to be accompanied at the hearing **(see Part 1)**. The Case Manager may be assisted by the Case Investigator(s) (where they are not appearing as a witness) or a senior HR member of staff. At all times during the hearing the panel, its advisors, the practitioner, his/her representative and the Case Manager must be present. Once a witness has given evidence he/she shall leave the hearing.

5.2 The procedure for the hearing will be as follows:-

- The Case Manager presents the management case (which may be by reference to the Case Investigator's report or a separate statement of case);
- The management witnesses will be called in turn. Each will confirm their witness statement and provide any additional information. The Case Manager may ask additional questions. The practitioner's representative may ask questions of the witnesses (if unrepresented the practitioner 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;
- The Chairman may ask the Case Manager to clarify any issues arising from the management case;
- The practitioner and/or their representative shall present their case and call any witnesses. The above procedure used for the management's witnesses shall be followed;
- The Chairman can request any points of clarification on the practitioner's case;
- The Chairman shall invite the Case Manager to make a short closing statement summarising the key points of the management's case;
- The Chairman shall invite the practitioner and/or his/her representative to make a short closing statement summarising the key points of their case. Where appropriate, this should include any grounds of mitigation;
- The panel shall retire to consider its decision.

6. THE DECISION

6.1 The panel has the discretion to make a range of decisions. A non-exhaustive list of possible decisions include:-

- No action required;
- Verbal agreement by the practitioner that there will be an improvement in clinical performance within a specified timescale confirmed in a written statement as to what is required and how it is to be achieved;
- Second stage warning to improve clinical performance within a specified timescale with a statement which is required and how this can be achieved;
- A final written warning that there must be improved clinical performance within a specified timescale and how this can be achieved;
- Termination of employment.

6.2 The decision must be confirmed in writing to the practitioner within 5 working days of the hearing and communicated to the Case Manager within the same timescale. The letter to the practitioner 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.

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

7. CAPABILITY APPEALS PROCEDURE

7.1 Remit of the Appeal Panel

7.1.1 This appeal procedure shall relate to decisions of a capability panel. The remit of the appeal panel is to review the findings and procedure followed by the capability panel. The appeal panel shall consider if the capability panel arrived at their decision fairly and reasonably based on:

- A fair and thorough investigation of issues;
- Sufficient evidence arising from the investigation or assessment on which to base the decision;
- Whether in all the circumstances the decision was fair and reasonable and commensurate with evidence heard.

7.1.2 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 re-hearing is required in the interests of a fair process.

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

7.2 The Appeal Panel

7.2.1 The appeal panel should consist of:-

- An independent person (trained in legal aspects of appeals) from an approved pool appointed by the NHS Appointments Commission. This person will act as the Chairman of the appeal panel;
- PHE's Chairman oralternate);
- A medically/dentally qualified member who is not employed by PHE (following discussions with the LNC/Medical Staff Committee).
- Where the practitioner is a clinical academic, a further panel member may be appointed in accordance with any agreed protocol between PHE and the relevant University.
- The appeal panel may be advised by:

- A Consultant from the same speciality or sub-speciality of the practitioner who is not employed by PHE; and
- A senior member of the Human Resource directorate.

7.2.2 The panel will be established by PHE and advice should be sought from the Chief People Officer.

7.2.3 The practitioner shall be notified of the composition of the panel, where possible, 25 working days prior to the hearing. If the practitioner objects to a panel member, the Chief People Officer shall liaise with him/her or their representative to seek to reach agreement. In the event agreement cannot be reached, the objections will be noted.

7.3 **Procedure and Time Limits in Preparation for the Appeal Hearing**

The following steps shall be taken:-

- Within 25 working days of the practitioner receiving the capability panel's decision he/she must send an appeal statement to PHE's Chief People Officer giving full grounds for the appeal;

- Within 25 working days of the appeal being lodged, the appeal hearing shall take place;
- 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 witness. In the event the panel requires 5 working days in advance of the hearing;
- At least 10 working days before the hearing a witness to be called, the Chairman shall liaise with the Chief People Officerate for the witness to supply a written statement to both parties;
- the practitioner shall confirm to the panel and the Case Manager whether he/she has any additional evidence on which he/she intends to rely. Copies of any documents or witness statements shall be provided with the notice of intention to call additional evidence;
- At least 5 working days before the hearing, the Case Manager shall confirm to the panel and the practitioner whether he/she has any additional evidence on which he/she intends to rely. Copies of any documents shall be provided. If the Case Manager's response to the practitioner'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 practitioner no later than 5 working days before the appeal hearing.

7.4 **Procedure at the Appeal Hearing**

The procedure for the hearing will be as follows:-

- The practitioner or his/her representative shall present a full statement of their case to the appeal panel which shall include all the grounds of appeal;
- The Case Manager and the panel shall be entitled to question the practitioner or his representative on the grounds of appeal;
- The practitioner or his/her representative shall present any additional evidence/witnesses. If they do so, the Case Manager and panel may ask questions;
- The Case Manager shall present a statement of the management case to the appeal panel which shall include the response to the grounds of appeal;
- The practitioner and the appeal panel shall be entitled to question the Case Manager;
- The Case Manager shall present any additional evidence/witnesses in relation to any new evidence from the practitioner or his/her representative and the panel may ask questions;
- The Case Manager shall sum up the management's case;
- The practitioner or his/her representative shall sum up their case. At this stage a mitigation statement may be made;
- The appeal panel shall retire to make a decision.

7.5 **The Decision of the Appeal Panel**

7.5.1 The appeal panel may:-

- Confirm the original decision of the capability panel;
- Amend the decision of the capability panel; or
- Order the case to be reheard in its entirety.

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

7.5.3 Where the appeal was about the practitioner's dismissal, he/she will not be paid from the date of termination as decided by the original capability panel. If the practitioner is reinstated following the appeal his/her pay shall be backdated to the date of termination of employment.

7.5.4 If the appeal panel decided that the whole case is to be reheard, the practitioner 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 applied.

8. OTHER ISSUES

8.1 Termination of Employment Pre-completion of Process

8.1.1 If a practitioner leaves PHE's employment prior to the conclusion of the above processes, capability proceedings must be completed wherever possible. This applies whatever the personal circumstances of the practitioner.

8.1.2 If the practitioner cannot be contacted via their last known address/registered address, PHE 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, Chief People Officer and in consultation with the External Independent Person. This action may include a referral to the GMC/GDC, the issue of an alert letter (HPAN) and/or referral to the police. If the concerns were due to conduct issues PHE needs to make a risk assessment if these concerns should be pursued. Each case will need to be considered on its own merits.

8.2 Sickness Absence of the Practitioner

Where during the capability process a practitioner becomes ill, they shall be dealt with under the PHE's sickness absence procedure and **Part 7** of this policy.
Where a practitioner's employment is terminated on ill health grounds PHE would normally take the capability procedure to a conclusion as set out in paragraph 6 above.

PART 7 HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH

1. INTRODUCTION

This procedure should be read in conjunction with **PHE's Managing Sickness Absence** policy, which will normally take precedence over this policy.
This part applies to the following circumstances:

- where the practitioner is off sick and no concerns have arisen about conduct or capability;
- where the issues of capability or conduct are decided by the Case Manager to have arisen solely as a result of ill health on the part of the practitioner;
- where issues of ill health arise during the application of the procedures for addressing capability or conduct.

Separate procedures are set out below in respect of each of these eventualities.

2. ACTION IN THE EVENT THE PRACTITIONER IS ABSENT PURELY DUE TO ILL HEALTH AND NO CONCERNS EXIST AS TO CONDUCT OR CAPABILITY

2.1 **Procedure**

2.1.1 Where a practitioner has been off sick for a continuous period of four weeks and there is no anticipated date for the practitioner's return to work and no concerns about capability or conduct have arisen, the following procedure will be adopted:

- A Case Manager will be appointed in accordance with **Part 2**;
- The Case Manager will refer the practitioner to Occupational Health for assessment;
- Occupational Health will provide an assessment to PHE and make recommendations as regards future management of the practitioner's ill health or proposals for re-integration of the practitioner into work;
- The Case Manager will seek the advice of the NCAS about the report and management of the practitioner's ill health;
- The practitioner (together with his/her representative if the practitioner so wishes) will meet the Case Manager (who will be accompanied by a member of Human Resources if (s)he wishes) to discuss the occupational health report and proposals for the practitioner to return to work;
- If the practitioner is unable to attend a meeting due to the state of his or her health, his/her ill health will continue to be monitored by the Case Manager in conjunction with Human Resources;

2.1.2 The Case Manager, in conjunction with Human Resources and the NCAS, shall monitor the practitioner's sickness and explore all of the options, including re-training, rehabilitation, variation of duties and/or working patterns, with the practitioner and his/her representative. As a last resort, in the event that the practitioner will be unable to return to work within a reasonable time and no reasonable steps can be taken by PHE to facilitate that return, the practitioner's employment may be terminated. Retirement on the grounds of ill health will be considered as part of the process and in accordance with the terms of the NHS Pension Scheme.

2.2 **Obligations of PHE and the Practitioner**

- PHE agrees that it will explore all options with the practitioner and seek to make reasonable adjustments to facilitate his or her return to work. The practitioner agrees that he/she will make himself/herself reasonably available for meetings or appointments with Occupational Health or such other medical advisor as may be reasonably deemed necessary or appropriate by PHE.

3. ACTION IN THE EVENT THAT ISSUES OF CAPABILITY OR CONDUCT ARISE SOLELY AS A RESULT OF ILL HEALTH ON THE PART OF THE PRACTITIONER

3.1 In the event that the Case Manager considers that the capability or conduct concerns may have arisen because of a practitioner's ill health, he/she should refer the practitioner to Occupational Health. Care must be taken in the letter to Occupational Health. It needs to set out:

- The practitioner's role and duties within it;
- Whether the practitioner has been signed off sick. If so, for how long and for what reason?
- Any evidence the practitioner has put forward suggesting that the concerns are caused by health problems rather than misconduct or incapability;
- Sufficient background about the concerns so that the Occupational Health adviser understands the context in which he/she is asked to advise;
- Specific questions to the Occupational Health adviser asking them to assess whether the ill health in question could have caused the practitioner to behave in a particular way and if that are likely in the particular case;
- Whether the practitioner is currently fit to carry out his/her duties. If not, when might he/she be fit to do so? Does his/her ill health compromise or potentially compromise patient safety? If so, how long will that be the situation or when will the Occupational Health advisor needs to review the position and give further advice? Will the practitioner be able to return on a restricted basis without jeopardising patient safety and, if so, when?
- A request for a written report from Occupational Health addressing each of the questions raised.

3.2 If the practitioner refuses to co-operate with such an Occupational Health assessment, that may be construed as a refusal to obey a reasonable management instruction to be dealt with under **Part 5** of this procedure. Once the Case Manager has the report from Occupational Health, he/she should decide whether he/she is satisfied that any concerns arise from ill health rather than misconduct or incapability. In that situation the Case Manager must then consider whether the practitioner should:

- Be removed from duties if the person is not on sickness absence;
- Have his/her practice restricted, for instance, by removing certain duties;
- Be excluded;
- Continue sickness absence, but on the strict basis that the situation will be reviewed in the event that the practitioner indicates he/she is fit to return to work. At that point the Case Manager should seek further advice from Occupational Health on this issue. If the practitioner is insisting on returning to work in circumstances where Occupational Health says he/she is not fit to do so and there could be a risk to patient safety, then the Case Manager is entitled to consider exclusion or a restriction of practice as appropriate;
- If sickness absence continues it will be dealt with under the PHE's Managing Sickness Absence policy and with due regard to the Equality Act 2010, if applicable.

4. WHERE ISSUES OF ILL HEALTH ARISE DURING THE APPLICATION OF THE PROCEDURES FOR ADDRESSING CAPABILITY OR CONDUCT

4.1 This section addresses circumstances where:

- Part way through a conduct or capability procedure the practitioner argues any concerns were caused by his/her ill health;
- Where the practitioner says a capability or conduct procedure should be delayed because of his/her ill health;
- Where a practitioner says conduct or capability procedures should be halted and purely handled as a health issue.

4.2 **Practitioner asserting concerns are caused by ill health**
4.2.1 In this situation the first step for the Case Manager is to obtain an Occupational Health report as set out above. If there is a dispute as to whether or not the practitioner's ill health caused the concerns or Occupational Health has been unable to offer a view on this, then the Case Manager may refer the practitioner to an external OH specialist provider for a further opinion. If Occupational Health advice is clear, the Case Manager is entitled to act on the basis of that advice. He/she is also entitled to act on the basis of the specialist's advice (if obtained) if that conflicts with the practitioner's medical advice.

4.2.2 The Case Manager should also seek advice from the NCAS on this issue. Where there is such a dispute the Case Manager will write to the practitioner within 5 working days of receiving the specialist's and Occupational Health's advice setting out his/her decision.

4.2.3 The Case Manager should confirm whether the matter will be dealt with as an ill health issue or under the capability or conduct procedure as appropriate. If the Case Manager determines that the issue is an ill health issue, he/she should follow the procedure set out above. If he decides the issue is a matter of conduct or capability, then that process will continue subject to what is set out below.

4.3 Delaying a conduct or capability procedure due to a practitioner's ill health
4.3.1 Where a Practitioner seeks the delay of an investigation, conduct or capability hearing due to ill health, he/she must, (without delay), seek such delay in writing providing supporting medical evidence. If no such written reasons or medical evidence is provided, the Case Manager is entitled to take this into account in deciding whether to delay the process. Any decision whether to delay the process is the responsibility of the Case Manager.

4.3.2 Where a practitioner says that he/she is unfit to attend a conduct or capability hearing or take part in an investigation, the Case Manager should refer the practitioner to Occupational Health promptly and in any event within 4 weeks of the sickness absence commencing to consider:

- The practitioner's general state of health at that point;
- The prognosis as to when the practitioner's health might improve;
- The practitioner's ability to give instructions to his trade or defence union representative to defend his/her position;
- The practitioner's ability to participate in the conduct or capability hearing;
- If the assessment is that the practitioner is unfit to give instructions or take part in the hearing, provide an opinion as to when he/she may be able to participate in the process;
- Provide an opinion on the likely impact of the procedure remaining on hold in the long term. Is there any benefit to the practitioner's health in moving forward with the procedure at a certain point?
- Asking for a written report addressing these issues.

4.3.3 The Case Manager should discuss any decisions as to whether to delay the proceedings with the NCAS. If, having taken all matters into account, the Case Manager is satisfied that circumstances require a delay to be lifted, he/she must write to the practitioner explaining this fact and giving reasons for such decision. If notice is given of a conduct or capability hearing, the Case Manager should explain that the practitioner is entitled to attend this hearing or ask a representative to attend in his/her absence and/or present written representations. Alternatively, the Case Manager may decide proceedings should re-start at a specified date.

4.3.4 Once an Occupational Health report has been received, the Case Manager should convene a meeting with the practitioner, his/her representative and the Chief People Officer

to consider the way forward. The Case Manager shall take into account the practitioner's views, but it remains the Case Manager's responsibility to ensure the process is effectively handled. The Case Manager may conclude that:

- A delay for a certain period of time is appropriate but the situation should then be reviewed at that point;
- A delay is appropriate for a certain period at which point the practitioner should be referred to Occupational Health once more for a further assessment at which point the situation will be re-assessed;
- The Occupational Health advice is clear that it would actually be beneficial to the practitioner to continue the process at a certain point. In doing so, the Case Manager is entitled to take into account the effect of a lengthy delay in the proceedings on an individual's ability to recollect events.

4.3.5 The practitioner must reasonably co-operate with Occupational Health. If he/she does not do so, for instance by unreasonably refusing to accept a referral to Occupational Health, then he/she may be subject to separate disciplinary actions. The Case Manager will further be entitled to take such issue into account in deciding whether to delay a conduct or capability hearing or investigation.

4.4 Practitioner request to terminate or modify conduct or capability proceedings

4.4.1 In the event that a practitioner requests that the scope of proceedings be modified or terminated due to the health issue, the Case Manager should refer the practitioner to Occupational Health within 4 weeks of such request. Again, the Occupational Health advisor should be asked specific questions as to the practitioner's state of health, ability to take part in the process, and the implications of the modification or termination sought on the practitioner's health. When a report is received from Occupational Health, the Case Manager should consider this report alongside any representations that the practitioner makes. The Case Manager should also take into account:

- Evidence suggesting there is a risk to patient safety.
- Evidence suggesting there is a risk to other staff.
- The seriousness of the concerns.
- Evidence of any serious dysfunction in the operation of the service in which the practitioner works.

4.4.2 The Case Manager is entitled to take these factors into account in determining whether to modify or terminate conduct or capability proceedings. The Case Manager should discuss this matter with the NCAS. Having done so, the Case Manager must write to the practitioner setting out his/her decision as to whether to modify or terminate the procedure and giving reasons for it. If the Case Manager determines it is inappropriate to modify or terminate the procedure, he/she should outline what next steps will be taken in the process. These might include:

- A further Occupational Health assessment;
- A delay in the proceedings until a specified date;
- Where the Case Manager considers the circumstances justify it, setting a date for a conduct or capability hearing.

5. PRACTITIONERS IN TRAINING GRADES WHERE ILL HEALTH ISSUES ARISE

Where a concern involves a training grade practitioner, PHE shall seek advice from the Training Coordinator and from Health Education England in each of the situations set out above.

6. REPORTING PRACTITIONERS WITH HEALTH CONCERNS TO REGULATORY BODIES

If a practitioner's ill health makes them a danger to clinical service delivery and he/she does not recognise this, or is not prepared to co-operate with measures to protect patients and the population, then exclusion from work must be considered and is potentially justifiable. Furthermore, the NCAS, GMC or GDC must be informed irrespective of whether or not the practitioner has retired on ill health grounds.

APPENDIX B

SUMMARY OF RIGHTS

This section summarises the rights of a practitioner under the PHE Responding to and managing concerns policy

If a practitioner is subject to action under the PHE Responding to and managing concerns policy his/her rights are:

1. To be accompanied and/or represented from the outset, by either:

- an accredited representative of a trade union or a defence organisation. That person may be legally qualified but he or she will not be acting in a legal capacity. For the avoidance of doubt this means that he /she may have a legal qualification but is not engaged by the trade union or defence organisation as a lawyer. This also precludes a trade union or defence organisation from instructing external solicitors or barristers to represent a practitioner; or
- another employee of PHE, friend partner or spouse. Sufficient time will be allowed for the representative or companion to offer advice and prepare the case. If the companion is legally qualified, he or she will not be acting in a legal capacity. Management will give the maximum assistance in securing representation promptly so the matter can be resolved without unnecessary delay.
- It is important to note that a disciplinary hearing is not equivalent to a legal court of justice, but that a practitioner may seek advice on the appropriateness of legal representation[2]

2. To be advised of the details of the alleged misconduct in writing prior to the interview.
3. To be told of the category of the alleged misconduct.
4. To be given on request a copy of any disciplinary action and this is retained on employee's personal file.
5. To be reminded in writing of his/her right of appeal in matters classed as serious or gross misconduct.
6. To be sent a copy of this summary of rights together with a covering letter.
7. To see all correspondence from NCAS and professional regulatory bodies, unless that body has expressly withheld permission for the correspondence to be shared.
7. Entitlement to all information relating to the allegations.

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

[2]http://www.hrlaw.co.uk/site/infobank/infobank_litigation/legal_representatation_at_disciplinary_hearings

APPENDIX C

DEFINITIONS

"Case Manager" is the person who has responsibility for overseeing investigations into concerns about a practitioner. Case Managers should have undertaken formal training (provided by NCAS or another equivalent body), with appropriate refresher training where necessary, and ongoing role-specific CPD. His/her duties are to:

- On first hearing about these concerns, decide whether they should be formally investigated.
- Notify the practitioner in writing of such investigation.
- Consider (usually with the Chief People Officer and Chief Executive) whether to restrict immediately a practitioner's duties or exclude him/her from work or take some other form of protective action.
- Upon receipt of the case investigator's report consider whether a formal procedure should be started (for instance a disciplinary hearing). At this stage, he/she will also consider whether any immediate restrictions or exclusion should be continued.
- Review any exclusion and determine after careful thought whether it should be continued.
- Prepare reports before the end of each four week exclusion period.
- Liaise with and seek the advice of the NCAS as set out in this policy.

"**Case Investigator"** is the person who is responsible for carrying out a formal investigation into concern(s) about a practitioner. He/she must :

- Have attended full NCAS (or equivalent) training for the case investigator role, and have maintained appropriate role-specific CPD.
- Carry out a proper and thorough investigation into the concerns.
- Involve an appropriately qualified clinician to investigate clinical concerns if he/she does not have such qualifications or expertise.
- Ensure that appropriate witnesses are interviewed and evidence reviewed.
- Ensure that any evidence gathered is carefully and accurately documented.
- Keep a written record of the investigation, the conclusions reached and the course of action agreed with the Responsible Office and or Medical Director and Chief People Officer.
- Meet with the practitioner in question to understand the practitioner's case.
- Prepare a report at the conclusion of the investigation providing the case manager with enough information to decide how to take it forward.
- Provide updates and assistance to the External Independent Person on the progress of the investigation.

- Provide factual information to assist the case manager in his/her review of any exclusion.

”External Independent Person” is not an employee of PHE. S/he will ensure that the processes set out in these guidelines are being followed but do not make decisions on any issues such as whether to exclude from work. S/he will:

- Ensure that the investigation is being carried out promptly and in accordance with these guidelines.

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

"Clinical Advisor" is the person who provides clinical advice and guidance to the case investigator, if relevant, where clinical issues arise. S/he will have appropriate specialist skills to advise. Where no such person is available or is precluded from advising (for instance if he/she raises the concerns) PHE will seek to identify a person outside its employment to advise.

“Training Coordinator” The training coordinator may be involved in cases involving doctors and dentists in training. When such an incident occurs PHE will liaise with the Responsible Officer and/or Medical Director or other designated person from Health Education England to agree how the process will be managed within the parameters of the educational training programme.

APPENDIX D

AUTHORISATIONS

Set out below are lists of those authorised to fulfil certain roles under these guidelines. PHE reserves the right to add to or remove from these lists as it considers necessary.

Case Managers

The following are authorised by PHE to act as case managers: the Responsible Officer, Deputy Responsible Officer, Medical Director (or Acting Medical Director), an appropriate Director appointed by the Responsible Officer and/or Medical Director (in a case not involving a Consultant) or any Responsible Officer and/or Medical Director or Director not employed by PHE who has been requested to undertake this role by the Chief Executive of PHE. All case managers must have completed full NCAS (or equivalent) training for the role, and must maintain suitable relevant continuing professional development.

Case Investigators

The following are authorised by PHE to act as case investigators: clinical and non-clinical directors and general managers who are suitably trained to act in this role. All case investigators must have completed full NCAS (or equivalent) training for the role, and must maintain suitable relevant continuing professional development.

Employees with the power to exclude doctors from work or restrict their practice

The following are authorised to exclude or restrict practice:

- The Chief/Acting Chief Executive
- The Medical Director/Acting Medical Director
- The Director/Acting Chief People Officer
- Clinical Directors (for practitioners below the grade of consultant).

APPENDIX E

CHECKLIST ON EXCLUDING/RESTRICTING PRACTICE

WHEN CONCERNS FIRST ARISE WHO DISCUSSED THIS?	**[Insert names]**
WHEN?	**[Insert date]**
SUMMARISE THE AREAS OF CONCERN	**[Insert summary]**
HAS THE NCAS BEEN CONSULTED?	YES/NO. **[Give name of NCAS officer spoken to if applicable and when discussion took place]**
IF SO, WHAT WAS ITS ADVICE?	**[Insert summary]**
HAS AN NCAS ASSESSMENT BEEN CONSIDERED? IS IT AN APPROPRIATE ACTION? IF NOT, WHY NOT?	YES/NO. **[Insert summary answer]**
HAS SUPERVISION BY THE MEDICAL DIRECTOR BEEN CONSIDERED? IS IT AN APPROPRIATE ACTION? IF NOT, WHY NOT?	YES/NO. **[Insert summary answer]**
HAS RESTRICTING THE PRACTITIONER'S CLINICAL DUTIES BEEN CONSIDERED? IS IT AN APPROPRIATE ACTON? IF NOT, WHY NOT?	YES/NO. **[Insert summary answer]**

APPENDIX F

TEMPLATE LETTER TO SEND TO PRACTITIONER BEING IMMEDIATELY EXCLUDED/RESTRICTED FROM PRACTICE

STRICTLY PRIVATE & CONFIDENTIAL
ADDRESSEE ONLY
[Insert name and address]
[Insert date]

Dear **[insert name of practitioner]**
I am writing to inform you that serious concerns have been raised concerning your **conduct/ professional competence/health] [delete / add to as appropriate]**. These concerns are that:
[Set out details of the concerns]
In accordance with Department of Health guidance and PHE procedure, I will be the case manager dealing with your case. In the circumstances, I have discussed this case with **[insert names]**. I have also consulted with the NCAS.

The above concerns are very serious and need to be investigated further. I have therefore appointed **[insert name]** to investigate these concerns with all proper speed. It is anticipated that **[insert name]** will complete his/her investigation by **[insert date four weeks from date of letter]**. I will then endeavour to write to you within five days of the completion of the investigation to provide you with a copy of the investigatory report.
In the meantime I and **[insert names]** have considered and consulted with the NCAS over the following options:

- Your clinical duties being carried out under the supervision of the Medical Director.

- A restriction of your clinical duties pending the investigation or any formal procedure that may follow if considered necessary

- Asking you to cease clinical duties pending completion of the investigation/any procedures flowing from it

- An NCAS assessment

- Immediately excluding you from work for **[insert period up to a maximum of two weeks]**

After the most careful consideration, I have decided that it is appropriate to **[insert conclusion]**. I did not consider the other options I have set out appropriate because:
[Set out reasons for rejecting other options.]

I considered that **[insert option decided upon]** was appropriate because:
[Insert reasons for your choice of option.]

This information must be treated in the strictest confidence by all concerned, including yourself. You are, of course, encouraged to discuss it with your professional adviser/defence organisation/representative. Otherwise you should not discuss it further.
[Insert if excluding from work.]
Exclusion from work is a neutral act. It does not denote guilt or any suggestion of guilt. During the period of exclusion you
[either]

may only attend PHE's premises for audit meetings, research purposes, and study or continuing professional development. There is no limitation on you attending PHE premises to receive medical treatment if appropriate.
[Or]
you should not attend PHE's premises unless specifically invited to do so by me or **[insert name of case investigator]**. This does not affect your ability to come to receive medical treatment if appropriate.

During your exclusion from work you will continue to receive your full salary and benefits. You must remain ready and available to work. You must seek permission for annual and study leave from me in the normal way. During your working hours you must be available and contactable to provide information to **[insert name of case investigator]**. If you are unavailable for work during your exclusion, this may result in PHE stopping your pay.
[Applies where restriction on practice is agreed with the practitioner]

Please signify your agreement to the restrictions on your practice by signing and returning the enclosed copy of this letter. If you do not agree to abide by these restrictions, PHE reserves the right to review this situation and any actions it may need to take in order to safeguard patient interests.
[Applicable in all cases]
[Insert name], the External Independent Person is designated to ensure that your case is dealt with fairly and promptly.
[Applicable in exclusion cases]
[You may make representations to **[insert name]** on your exclusion from work.

A meeting has been scheduled for you to meet with myself on **(date)** at **(time)** in **(location**) to discuss the progress in the case. You will be entitled to be accompanied at this meeting by a trade union/staff side representative, a work colleague not likely to be called as a witness in the case or a friend (not acting in a legal capacity).
If you have any questions, please contact me.

Yours sincerely
[Insert name of case manager]

APPENDIX G

CASE MANAGER'S INITIAL ASSESSMENT REPORT

General Principles

This Guidance relates to when initial concerns have been raised with the Case Manager. The Case Manager should decide how such concerns should be taken forward in accordance with **Part 2**.

If an immediate decision on how to deal with the concerns is deemed unnecessary, then the Case Manager should set out his/her decision in an Initial Assessment Report, in accordance with the guidance below. Where immediate action is necessary and it is not practicable to document the decision beforehand, then it would be best practice to produce an Initial Assessment Report, after the event so that there is a record of the reasons for the decision.

The Initial Assessment Report is not intended to be, and cannot be, a thorough investigation of all the issues arising from the concern. The Case Manager is only concerned in investigating the concern to the extent that it is necessary to make a preliminary decision on how matters should be taken forward.

The Case Manager's preliminary decision on how the matter should be taken forward, as set out in the Initial Assessment Report, will not in any way affect the Case Investigator's conclusions (if a Case Investigator is later appointed) or the fact that the Case Manager may subsequently decide that it is more appropriate to take matters forward in another way.

The Report

The Initial Assessment Report should be succinct, and would usually include the following:

- a clear statement of the apparent concern(s);

- an explanation of any steps the Case Manager has taken to clarify the concern(s). It should also identify any evidence or witnesses that have been identified by the Case Manager. Any evidence identified by the Case Manager as part of this initial assessment should be secured in a safe place and passed to the Case Investigator if there is a formal investigation subsequently;

- any advice received from the NCAS should be noted together with a record of the name of the NCAS officer and when the advice was given;

- the Case Manager's view on how the matter should be dealt with in accordance with paragraphs 1 - 7, **Part 2** and the reasons for this should be set out. For example, the Case Manager may decide that no serious concerns have arisen and the matter may be dealt with by counselling. By way of further example, the Case Manager may decide that a formal investigation is necessary before he or she can decide upon the appropriate procedure to apply;

- the Case Manager should identify what the next steps will be and who will undertake these, in accordance with this policy.

The Initial Assessment Report should be signed and dated.

APPENDIX H

TERMS OF REFERENCE FOR CASE INVESTIGATOR

Where a Case Manager decides that a formal investigation is necessary, Terms of Reference must be produced in order to focus the investigation.

The Terms of Reference should usually include the following:

- identification of the Case Manager, the Case Investigator and the External Independent Person;

- a clear statement of the concerns which are the subject of the investigation

- any evidence collected by the Case Manager should be appended to the Terms of Reference and any relevant witnesses should be identified. It should however be stressed that the Case Investigator's investigation is not limited to considering this evidence alone and it is entirely for the Case Investigator, at his or her discretion, to determine how best to investigate the concerns set out in the Terms of Reference;

- identification of any Human Resources advisor and/or a specialist clinician working in the same area as the practitioner who will assist the Case Investigator;

- the date by which the investigation should be completed or by which a progress report should be provided; and

- the date by which the case investigator's report should be presented to the Case Manager.

The Terms of Reference should be signed and dated by the Case Manager and the practitioner under investigation.

APPENDIX I

FRAMEWORK FOR CASE INVESTIGATOR'S REPORT

The investigation report must be written with the full input of the clinical advisor where there is one. The Case Investigator must refer back to the advice within this policy to ensure he/she is complying with it. A clear and thorough report should be prepared to aid full understanding of the case and provide assurance.

The framework below is for guidance purposes only.

.

Terms of reference

Set out the brief provided by the Case Manager. Set out the scope of the issues or concerns being investigated.

Background Information

Briefly set out the circumstances leading to the investigation. Summarise the incidents causing concern and how they came to the attention of PHE's senior management.

Investigatory steps

Set out what was done to carry out the investigation. Which witnesses were interviewed? What documentation was looked at? Was there an associated serious incident investigation into the same matter? What other steps were taken in the course of the investigation?

Evidence gathered and findings of fact

Set out the main evidence gathered in respect of each of the concerns investigated. Then set out the findings of fact concern by concern. Is there evidence to substantiate the concern? What has been said or found in response, to provide an answer to the concern? The Case Investigator needs to show that he/she has considered the evidence, including any apparent conflicts.

In such situations the Case Investigator should explain which evidence appears preferable and why that is the case.

Conclusions

Give a preliminary view as to whether there is a case to answer on each of the concerns cross referencing to the findings of fact. Are there other explanations or mitigating factors which may impact on the decision regarding whether there is a case to answer? For instance is there evidence of any contributory systems failure rather than the practitioner being the source of the concern?

Specifically deal with any assertions that the concerns arise from an underlying health issue. The Case Investigator should be able to ensure that the case manager has sufficient evidence to then consider what further actions are required.

Appendix

Appended to the report should be:

- copies of the statements gathered in the course of the investigation.
- documents considered by the Case Investigator. These should generally be indexed and organised in chronological, paginated order with the oldest documents first

It will probably be easier if the appendix is prepared as a separate bundle of documents for ease of reference especially where there are a lot of documents.

Preliminary Report

If the Case Investigator is requested to produce a preliminary report by the Case Manager in order for the Case Manager to make a determination on the issue of formal exclusion, then this preliminary report should contain the following:

- a statement on the concerns being investigated;
- an explanation of what investigations have been undertaken to date;
- an explanation of the evidence gathered to date (this can be by reference to documents or witness statements appended to the preliminary report);

The Case Investigator should provide sufficient information in the preliminary report to allow the Case Manager to decide whether a formal exclusion is necessary.

APPENDIX J

CHECKLIST ON MAKING A FORMAL EXCLUSION/RESTRICTING PRACTICE

HAS A CASE INVESTIGATOR PREPARED A PRELIMINARY REPORT?	**Yes/No**
WHAT DOES IT CONCLUDE?	**[Provide summary of key conclusions]**
HAS THE NCAS BEEN CONSULTED? IF SO, WHAT WAS THEIR ADVICE	YES.1 [**Summarise their advice]**
HAS A CASE CONFERENCE BEEN HELD? WHEN? WHO ATTENDED IT	YES.2 [Insert date and attendees of it]

APPENDIX K

GUIDANCE TO CLASSIFICATION OF DISCIPLINARY OFFENCES

It is not possible to prescribe, classify and list every possible circumstance which would require disciplinary action. The following list therefore gives examples of the most obvious serious offences which may be classified as gross misconduct therefore justifying summary dismissal (dismissal without notice). The list is not exhaustive or exclusive and is intended as guidance only.

1. Unauthorised removal, use or theft of property belonging to PHE, another employee, a patient or visitor.

2. Fraud or dishonesty, e.g. signing in for another employee or allowing such an arrangement to occur, defrauding PHE of resources by wilfully falsifying records or booking of work or defrauding patients or staff (NB further guidance on this issue is contained in PHE's fraud policy and procedure).

3. Markedly irresponsible and / inappropriate behaviour including being under the influence of alcohol or non-prescribed drugs whilst at work or on-call.

4. Negligent and / or reckless acts or omissions which endanger the safety of staff, patients or members of the public.

5. Gross insubordination, for example wilful failure to carry out reasonable instructions or wilful disobedience of the written or oral instructions of a manager or supervisor.

6. A criminal offence either at work or outside of work where the latter is liable to bring PHE into disrepute or which necessitates the removal of the employee from the post to which they had been appointed.

7. Wilful damage to PHE premises or property.

8. Disclosure of confidential information to unauthorised persons, particularly in relation to a patient or member of staff.

9. The illegal possession of drugs and/or the administration of such drugs to oneself or others on PHE premises or allowing such a practice to take place.

10. Non-compliance with safety, health or fire rules where such non-compliance could pose a serious risk to themselves or others, and where the rules have been known to staff.

11. Unauthorised acceptance of payment from patients, visitors, contractors or other parties having dealings with PHE which might be interpreted as seeking to exert influence to obtain preferential consideration.

12. Physical, verbal or other bullying or harassment or discrimination including harassment on the grounds of race, religion, sexual orientation, sex or disability.

13. Physical or verbal abuse, of a patient, employee or visitor.

14. Falsification of a qualification which is a stated requirement of PHE or which might result in additional remuneration.

14. Non-declaration of a criminal offence.

15. Unauthorised absence from work.

16. An act sufficiently serious to cause substantial damage to PHE’s reputation.

APPENDIX L

MANAGERS WITH AUTHORITY TO SANCTION

This section below identifies those managers authorised to take disciplinary action in accordance with the policy.

1. First stage warnings

The authority to issue a first stage warning rests with the investigating manager's Line Manager (or appropriate equivalent) responsible for direct or indirect management of the individual.

2. Second stage warning/final written warning

The authority to take this level of action will be within the remit of those managers holding posts reporting directly to the Centre or Regional Director or appropriate equivalent.

3. Dismissal/disciplinary transfer/demotion

The authority to dismiss (or transfer or demote where dismissal of the practitioner can be justified) will be within the remit of the Chief Executive (as delegated to national directors), national directors and, with the national director's authorisation, those who report directly to them

NB: *Please refer to the PHE Disciplinary Policy and Procedure.*

Appendix M Outline of the supporting guidance notes associated with this policy

Summary outline of the four sets of guidance notes

GN1: Identifying conduct, capability or health concerns about doctors and dentists in PHE	Defining Fitness for purpose The role of managerial and professional appraisal Local resolution Performance Assessment tool Local action and remediation Escalation
GN2: Supporting doctors and dentists with conduct, capability or health concerns in PHE	Staff health and wellbeing Keeping the doctor engaged Recording sickness Access to the Employee Assistance Programme Occupational health assessments
GN3: Preparing for the investigation of conduct, capability or health concerns about doctors and dentists in PHE	How an investigation can help Different types of investigation: conduct, capability, grievances, bullying and harassment Appointment of the Case Manager and Case Investigator Report format Dealing with problems and challenges
GN4: Remediating and developing doctors and dentists in PHE.	Preventing poor performance Principles Back–on–Track Responsibilities NCAS advice services NCAS assessments Action planning Measuring success

Action plan

	Recommendation	Action	By whom	By when	Outcome	Status
1	Early intervention to resolve issues	Ensure that relevant training course developed in HR and the ORO to highlight the responsibility on managers to resolve issues early	People Directorate and ORO	End of December 2018		
2	Early intervention to resolve issues	Train a new cadre of mediators	People Directorate	End of January 2019		
3	Early intervention to resolve issues	Develop a mediation feedback service	People Directorate	End of March 2019		
4	Training for those involved in casework	Ensure that all those trained by NHS Resolution continue to receive on-going development through the ORO	ORO	End of March 2019		
5	Training for those involved in casework	Managers at CS Grade 6 and above to be trained in PHE's Disciplinary and Grievance process.	People Directorate	End of June 2019		
6	Training of those involved in casework	Include signposting of training on Unconscious Bias into Line Manager training modules	People Directorate	End of March 2019		
7	Training of those involved in casework	Ensure that the Senior Leadership Team are all trained appropriately when investigating claims of race discrimination	People Directorate	End of March 2019		
8.	Ensuring policies and procedures are easily understood	Develop a guidance document that assists managers, HR and the ORO to navigate more easily between the ORO policies and HR policy	People Directorate and ORO	End of March 2019		

9	Ensuring policies and procedures are easily understood	Development of a complex casework SOP	People Directorate, OH and ORO	End of March 2019		
10	Conduct of Investigation	Clarify ToR development in the ORO policy	ORO	TBC		
11	Use of documents relating to prior investigations.	Review the HR documentation retention schedule with the Information Governance office	People Directorate	End of March 2019		
12	Use of documents relating to prior investigations.	Reports used in investigations should only be redacted to protect essential confidential information - communication to be sent to all HR BPs and HRAs to confirm this.	People directorate and Responsible Officer's Office	End of December 2018		
13	Use of documents relating to prior investigations.	To ensure that all grievances are seen through to completion, even if just via correspondence once an individual has left PHE – communication to be sent to all HR BPs and HRAs to confirm this.	People Directorate	End of December 2018		
14	Quality Assurance	New Revalidation policy	Responsible Officer's Office	TBC		

Public Health England

Protecting and improving the nation's health

Revalidation Steering Group

Title of meeting	Revalidation Steering Group
Date	4 June 2018
Sponsor	Imogen Stephens
Presenter	Liz Scott
Title of paper	Employment Tribunal Review – Learning for PHE and the Office of the Responsible Officer.

1 Purpose of the paper

The purpose of the paper is to present the learning for PHE and the Office of the Responsible Officer following an Employment Tribunal ruling.

2 Background

In his written decision, the presiding judge for an Employment Tribunal (ET) judgement was critical of PHE. A review was undertaken to see where systems, procedures and processes could be improved and an action plan was drawn up. This brief paper updates RSG on the implementation of that action plan.

3 Recommendation

The Revalidation Steering Group is asked to:

Note the implementation of the action plan following the review of the ET ruling

Authors Liz Scott and Imogen Stephens

Date 17 May 2018

EMPLOYMENT TRIBUNAL REVIEW – LEARNING FOR PHE AND THE OFFICE OF THE RESPONSIBLE OFFICER

In his written decision, the presiding judge for a recent Employment Tribunal (ET) judgement was critical of PHE. It is therefore beholden upon the Office of the Responsible Officer (ORO) to review the case to see where systems, procedures and processes can be improved. This brief paper summarises those areas that fall within the remit of the Responsible Officer (RO) where there could be improvements.

Policy Issues

Maintaining Professional Standards

The first issue concerns the timescales in PHE's current Policy and Guidance notes ('Maintaining Professional Standards for doctors and dentists in PHE', MPS) for the investigation which are unrealistic. They are in line with the Department of Health policy Maintaining High Professional Standards, but in common with anecdotal experience from the rest of the NHS, these timescales are very rarely met.

Despite this being a common observation, it is beholden upon those involved with investigations to ensure that all stages of the investigation process are completed as rapidly as possible, whilst ensuring the process is fair and comprehensive.

An audit has been undertaken of the timescales for the 14 investigations that have been completed since PHE came into existence. This demonstrated that the biggest single area for delay was the completion of the investigation itself. The findings of this audit are being reviewed by the ORO in the light of advice from recent case investigators to reduce the time taken to complete investigations. The timescales in MPS will then be revised and incorporated into our newly developed policy and guidance: 'Responding to Concerns: maintaining high professional standards'. The second area concerns the External Independent person. This person has a clear remit within both MPS and 'Responding to Concerns' to ensure that the investigation proceeds in a timely manner and requires an individual who is actively involved.

The third area is in relation to which policy should be used for Bullying and Harassment allegations made against doctors. Recent advice from the National Clinical Advisory Service clarifies that investigations of doctors and dentists for purely 'conduct' concerns should be carried out under local organisational policies but, where doctors are concerned, these investigations should be overseen by the RO and conducted by appropriately trained case investigators (CIs) appointed by the RO.

Issues for the Office of the Responsible Officer (ORO)

Initial assessment report (IAR)

The MPS policy states that the IAR should be prepared by the Case Manager (CM). In practice, much of the material for the IAR is provided by individuals more closely involved, but the ORO should work with the CM to ensure that the IAR is robust. Specifically, should the IAR include third party statements or hearsay, or where it is reporting third party statements/hearsay, the Terms of

Reference (TsoR) for the investigation should include ascertaining the relevant facts. This is particularly important where there is an allegation of a pattern of behaviour/incidents.

Document version control

TsoR inevitably go through multiple revisions, resulting in a lack of clarity for those involved- especially the CI. It is proposed that version control should be used at all times, and that all draft TsoR should have a watermark stating 'draft' and the final ToR, once discussed with the practitioner, should be signed by the CI and have a watermark of 'final'.

It was also noted during the timeline audit that signed copies of the final ToR are not being retained. To do so would significantly decrease the risk of draft versions being used in error.

How to handle a poorer quality report

The CI's report for the ET case was of poor quality. It is difficult, even with hindsight, to know how management of this investigation could have been improved as it is important that the CM and the ORO are not felt to be attempting to influence the outcome of the investigation. Perhaps this would be an issue for discussion with the HR team who support all MPS investigations.

Filing systems

It emerged during the ET hearing that not all relevant correspondence had been found and produced. First, a method of central storage of all email correspondence needs to be developed. Secondly, a disciplined approach to the development and maintenance of online systems for labelling and filing of documents needs to be adhered to. This should be done proactively for all open cases and retrospectively for cases where a major document review is undertaken.

Issues for Case Investigators

Creating time

Many investigations take a considerable amount of time to complete. In part, this can be due to the complexities of operating within a national organisation, but more often it is due to the pressure of work on those undertaking the investigation (who are inevitably senior members of staff) and those being interviewed. There is already a clear expectation in the policy that line managers will expect individuals to prioritise participating in an investigation, but this perhaps needs identifying as an issue at an early stage and Director level action being taken. CIs may need some backfill to ensure that their normal role is covered. There may also be a role for the external independent person once this role is clarified.

There may also be a role for the ORO in supporting CIs, particularly with the development of a standardised, properly formatted template for reports and editing. CIs will need to be properly trained in the efficient and effective use of such templates, as the use of these both saves significant time and produces comparative and more consistent reports.

Courthouse/legal training

It is not unusual for an investigation to conclude in an ET. Whilst an ET is less formal than a Crown Court, it is still a very formal legal environment. All CIs and CMs should undergo courtroom training, along with any other individual who may be called to give evidence.

Preparation for an ET

Preparation for any court case cannot be delegated. Individuals must ensure that they are fully acquainted with the details of the case and their involvement in it. This means that significant periods of time must be set aside to prepare, which may require short-term reprioritisation and delegation of other critical programmes of work.

Liz Scott and Imogen Stephens
Office of the Responsible Officer
June 2017

Action plan

	Issue	Action	By whom	By when	Outcome	Status
1	Timescales in MPS unrealistic	Audit of previous cases to identify more realistic but challenging timescales	EAS	October 2017		Completed
		Revise MPS in the light of the timeline audit	EAS/AS	December 2017		Completed
		Identify avoidable causes of delay and actions to reduce them	EAS/ORO	November 2017		Completed
2	Version control system to be introduced when preparing Terms of Reference	Draft versions of Terms of Reference to be numbered and to have a draft watermark inserted	EAS/ORO	With immediate effect		Completed
		Signed version of final copy of Terms of Reference to be retained	EAS/ORO	With immediate effect		Completed
3	External independent person not sufficiently proactive when investigation delayed	Identify alternative external independent person	EAS	August 2017	Two individuals identified	Completed,
4	Initial assessment reports may be based on hearsay that requires investigating	DMG to ensure that all Terms of Reference include investigation of hearsay	PC	With immediate effect	Terms of Reference circulated to DMG.	Completed but ongoing.
5	Investigation reports not always of high quality	Joint seminar with Cis and HR support to agree how to handle a poorer quality report.	EAS/SD	May 2018		Completed
6	Support needed for Cis who are writing up complex reports	ORO to identify report writing and administrative support to CIs	EAS	August 2017	Support identified within the ORO	Completed
		ORO to consider developing a report template	EAS/ORO	August 2017	Not felt to be helpful at this time	Completed, but to be kept under review.
7.	Courtroom training	Cis and CMs to undergo	EAS	August 2017	Training given	Completed

		courtroom training				

ANNEXE D

Public Health England

Protecting and improving the nation's health

Analysis of Appraisals, Employee Relations and Engagement by Ethnicity and Other protected Characteristics

1. Introduction

Following a tribunal hearing that found against PHE, it was decided to commission a management report to examine the criticism and produce an action plan in response. One of the issues identified was the possibility of either conscious or unconscious institutional bias on grounds of ethnicity or other protected characteristics.

This report analyses recent data on appraisal outcomes, grievance submissions, grievance appeals, redundancy cases and staff engagement to determine whether any patterns or trends can be identified based upon ethnic background or other protected characteristics.

2. Methodology

All appraisals completed in 2017 and 2018 for staff below Senior Civil Service (SCS) grade were analysed to determine whether there were any identifiable trends by ethnicity or other protected characteristics. Following the 2017 appraisal round, changes were made to PHE's performance management processes to improve consistency and address variations between reports for staff on Civil Service and Agenda for Change terms and conditions. However, it should be noted that these changes were made to address generic issues and were not based on concerns about ethnicity or other protected characteristics. The report is at Enclosure 1.

An analysis of grievances, grievance appeals and redundancy cases, collectively known as Employee Relations cases, was conducted to determine whether there were any patterns or trends relating to ethnicity or other protected characteristics. The report is at Enclosure 2.

The results of the 2017 PHE Staff Survey were analysed by ethnicity and the raw data is at Enclosure 3.

Detailed analysis of individual cases was not carried out to determine whether there was any indication of discrimination in specific cases. Findings therefore are based upon comparison by characteristic grouping and identify generic trends only.

3. Findings

Analysis of 2017 and 2018 appraisals identified no statistically significant differences in the levels of ‘Excellent’ or ‘Outstanding’ rating based on ethnicity or other protected characteristics.

Analysis of 2017 appraisals identified that staff with a declared disability (around 2% of staff eligible for appraisal) received a higher level of ‘Improvement Required’ ratings. This observation remains under review.

More in-depth analysis of 2018 appraisals identified that black/black British staff achieved significantly lower levels of ‘Outstanding’ ratings when compared to the average and to other ethnic groups.

Further analysis identified that junior grades within NIS laboratories appeared to be the main cohort affected by the statistical anomaly and an action plan was being raised by the NIS Senior Management Team to investigate further and identify remedial actions.

Analysis of grievances, grievance appeals and redundancy cases indicated no evidence of systemic discrimination on grounds of ethnicity or other protected characteristics.

Analysis of the 2017 PHE Staff Survey results indicate only a few clearly identifiable statistical differences in positive responses by ethnic background these are:

- I am sufficiently challenged by my work.
- My work gives me a sense of personal accomplishment.
- General adequacy of the pay and benefits package.

The Staff Survey indicated an overall positive response (79%) to questions about inclusion and fair treatment, and also that PHE is committed to creating a diverse and inclusive workplace.

There is a significant trend toward less positive responses to the staff survey from staff who do not wish to state their ethnic origin (approximately 9% of total PHE staff). Consequently, it is not possible to determine how many of these negative responses may come from ethnic backgrounds other than white.

The Staff Survey indicated an overall positive response (79%) to questions about inclusion and fair treatment and this was consistent across all ethnic groups.

4. Conclusions

Analysis of appraisals, grievances and staff engagement identifies no clear trends that indicate a PHE-wide culture of institutional conscious or unconscious bias.

There are pockets of statistical anomalies that are being investigated to determine root causes and identify remedial actions.

The 9% of staff declining to state their ethnic origin on the PHE 2017 Staff Survey indicates a degree of distrust and the need to better communicate the reason for collection of this data in order to better target solutions to issues rather than individuals themselves.

Unwillingness by some staff to enter ethnicity information on ESR also inhibits management's ability to identify trends in Employee Relations cases.

Enclosures:

1. PHE Analysis of Appraisal Outcomes
2. Grievance, Grievance Appeals and Redundancies Case Summary dated 12 November 2018
3. ORC International Analysis of PHE 2017 Staff Survey by Ethnicity

Public Health England

Protecting and improving the nation's health

Analysis of appraisal outcomes

1. Introduction

1.1. PHE is responsible for developing and implementing an annual performance management (appraisal) process for all staff other than those employed on Senior Civil Service (SCS) contracts. This covers nearly 5,000 staff, including those employed on medical and dental terms and conditions. The performance management process for SCS staff is separate to this and mandated by the Cabinet Office.

1.2. PHE's performance management process is well-supported across the organisation, with completion rates in excess of 90% in both 2017 and 2018.

1.3. Detailed analyses of appraisal outcomes across a range of staff characteristics (including the majority of protected characteristics) have been undertaken in both 2017 and 2018. These have used statistical testing to assess whether or not there were any significant differences in outcomes across different staff groups or protected characteristics.

1.4. The 2017 analysis was discussed in detail with representatives of PHE's Partnership Forum, who were supporting work led by the People directorate to refresh PHE's approach to performance management. It was also presented to the full Partnership Forum meeting in December 2017.

1.5. The 2018 organisational level analysis has recently been undertaken and was discussed at the PHE Pay Committee meeting on 24th September. Following this meeting a further, more detailed analysis of appraisal outcomes across different ethnic groups was requested. This was discussed at the Pay Committee meeting on 18th October and referred to the Management Committee meeting on 23rd October.

2. Key findings – 2017

2.1. The PHE performance system has five ratings. The level of the highest rating (called 'Excellent' in 2017) was analysed across the following characteristics:

2.1.1. Grade

2.1.2. Terms and conditions of employment

2.1.3. Gender
2.1.4. Ethnicity (aggregated as white and BAME staff groups)
2.1.5. Disability
2.1.6. Sexual orientation
2.1.7. Religion/belief

2.2. Significant differences in the level of 'Excellent' ratings were seen across staff at different grades and between those on Civil Service and Agenda for Change terms and conditions. The changes that were made to PHE's performance management during 2018 have been designed to improve consistency and to reduce this variation.

2.3. At an organisational level no statistically significant differences in the levels of 'Excellent' ratings were seen based on gender, ethnicity, disability, sexual orientation or religion/belief.

2.4. The one area of concern noted was that staff who had declared a disability (only around 2% of those eligible for a PHE appraisal) received a higher level of 'Improvement Required' ratings. Given the small number of staff involved this observation was noted and kept under review in 2018.

3. Key findings – 2018

3.1. As highlighted in paragraph 2.2, several changes were made to PHE's performance management system ahead of the 2018 appraisals. This included clearer guidance for managers, more positive language to describe performance outcomes and links to the Civil Service Competency Framework to support the assessment of behavioural performance.

3.2. Analysis of performance outcomes indicated that the changes to the process had helped to achieve a more realistic ratings distribution and a more even distribution of the highest rating (now called 'Outstanding') across different grades. A significantly higher proportion of staff on Civil Service terms and conditions continued to receive 'Outstanding' ratings compared to those on Agenda for Change terms and conditions.

3.3. The analysis by protected characteristics outlined in paragraph 2.1 was repeated for 'Outstanding' ratings. This again showed no significant difference in outcomes by gender, disability, sexual orientation or religion/belief.

3.4. This year we were able to undertake the analysis by ethnicity at a more granular level. This showed that black/black British staff achieved significantly lower levels of 'Outstanding' ratings (12%) compared to all other staff (20%) as well as the white, mixed and Chinese/any other ethnicity staff groupings.

3.5. This was discussed in detail at Pay Committee on 24th September and a detailed, directorate level analysis was commissioned. This work looked at PHE's five largest directorates, representing 94% of submitted appraisals.

3.6. There were a range of outcomes in terms of the level of 'Outstanding' ratings across different ethnic groups in different directorates. The only directorate where there was a lower outcome for black/black British staff which was statistically significant was the National Infections Service (NIS).

3.7. This was investigated in more detail in NIS Laboratories, which account for around 75% of the NIS workforce. This showed that black/black British staff were more likely to be employed in more junior grades, as well as to receive fewer 'Outstanding' ratings in appraisals, compared to their white colleagues. The over-representation of black/black British staff in more junior grades was particularly acute in NIS compared to PHE overall.

3.8. The supplementary report to PHE Pay Committee on the findings of this analysis has been escalated to the PHE Management Committee. The report recommended a series of actions that included undertaking a root cause analysis with the NIS senior management team to identify practical actions to improve appraisal outcomes for black/black British staff in NIS.

Grievance, Grievance Appeals and Redundancies Case Summary

12 November 2018

1. Introduction

PHE People Directorate collates and monitors information relating to employee relations (ER) cases. ER is the term used to describe all the aspects of managing the employment relationship and covers several areas including communication and staff involvement, trade unions, collective bargaining and conflict and dispute procedures.

In 2018 there have been 288 (5.7%) ER cases within a workforce of approximately 5000 staff.

This summary report focuses on grievances and appeals and known protected characteristics. It must be noted that reporting uses data held in ESR and in some categories little or no data is held and therefore is unreliable for reporting purposes.

2. Total Number of Grievances Cases

As of 31 October 2018 PHE had a total of 33 grievances of which 15 were closed and 18 active.

3. Reason for Grievances

Table 1 below shows the reasons for grievances. Off the 33 cases, 10 related to bullying and harassment and 8 terms and conditions. Individual and other reasons related to restructures, repayments or relationship issues not defined as bullying and harassment.

Grievances related to bullying and harassment is the highest at 10. This however equates to 0.2% of the PHE workforce which is a very low number.

As a result of the transition in 2013, PHE employs staff on a number of different terms and conditions including medical and Dental, Agenda for Change (current and TUPE protected), Civil Service and University. The difference in these terms can and does lead to grievances

Table 1: Reason for Grievances	2018/19
Bullying and Harassment	10
Terms and Conditions	8
Individual	6
Other	9
Total	**33**

4. Grievances and Protected Characteristics

4.1 Ethnicity (aggregated as white and BAME staff groups)

Table 2 below reflects the ethnicity of staff raising grievances. The data reflects that of known ethnicity there is a comparable number of staff raising grievances in the bullying and harassment and individual categories. In the terms and conditions and other categories, there is a higher number of white staff raising grievances.

Table 2: Grievances & Ethnicity	White	BAME	Not Stated	Total
Bullying and Harassment	4	4	2	10
Terms and Conditions	6	2	0	8
Individual	3	3	0	6
Other	4	2	3	9
Total	**17**	**11**	**5**	**33**

4.2 Disability

Off the 33 grievances, 2 staff declared having a disability; all other staff did not have a disability. The 2 staff with a declared disability were white.

4.3 Gender

Table 3 below reflects the sex of staff raising grievances by ethnicity. The table reflects that 21 (63%) women raised grievances compared to 12 (36%) males. This may initially appear disproportionate however when considered against the overall organisation, this would appear proportionate at the PHE workforce has more females (64%) than males (36%).

Table 3: Grievances & Gender	White	BAME	Not Stated	Total
Female	10	7	4	21
Male	7	3	2	12
Total	**17**	**10**	**6**	**33**

5. Grievance Appeals and Protected Characteristics

5.1 Number of Appeals by Ethnicity and Gender

Table 4 below shows that there were 7 grievance appeals; 2 for bullying and harassment, 3 for terms and conditions and 2 for other reasons.

The table also reflects the breakdown of gender across the appeals.

Table 4: Grievances Appeals	White	BAME	Not Stated	Total
Bullying and Harassment	1 (F)	1 (F)	0	2
Terms and Conditions	3 (2 F, 1 M)	0	0	3
Individual	0	0	0	0
Other	1 (M)	1 (M)	0	2
Total	**5**	**2**	**0**	**7**

5.2 Disability

No staff raising an appeal had a declared disability.

6. Redundancies

6.1 Number of Redundancies

In the last year PHE has had 21 redundancies. Of these, 9 were voluntary and 12 compulsory. This equates to 0.4% of the PHE workforce.

6.2 Redundancies by Grade

The table also reflects grades of staff and shows that a higher number of redundancies were experienced in grades AO, HEO and SEO but that overall redundancies are low.

Table 6: Redundancies by Grade	VR	CR	Total
AA / AfC 3	0	0	0
AO / AfC 4	2	4	6
EO / AfC 5	1	1	2
HEO / AfC 6	4	3	7
SEO / AfC 7	2	2	4
G7 / AfC 8a	0	0	0
UG7 / AfC 8b	0	0	0
G6 / AfC 8c	0	1	1
SCS / Medical	0	1	1
Total	9	12	21

6.3 Redundancies and Protected Characteristics

6.3.1 Ethnicity

Table 7 reflects ethnicity in both the voluntary and compulsory redundancy categories. In the voluntary redundancies 6 staff were white, 0 BAME and 3 did not have an ethnicity stated. In the compulsory redundancies 7 staff were white, 2 BAME and 3 not stated.

Table 7: Redundancies and Ethnicity	White	BAME	Not Stated	Total
Voluntary	6	0	3	9
Compulsory	7	2	3	12
Total	13	2	6	21

6.3.2 Disability

Table 8 reflects those staff with a declared disability. In the voluntary category 2 staff declared a disability and 1 in the compulsory category.

Table 8: Redundancies and Disability	Yes	No	Not Stated	Total
Voluntary	2	1	6	9
Compulsory	1	5	6	12
Total	3	6	12	21

6.3.3 Gender

Table 9 reflects the gender breakdown of staff experiencing redundancy. The table shows that females account for 66% of those made redundant and males 34%. This may initially appear disproportionate however when considered against the overall organisation, this would appear proportionate at the PHE workforce has more females (64%) than males (36%).

Table 9: Redundancies and Gender	Male	Female	Not Stated	Total
Voluntary	4	5	0	9
Compulsory	3	9	0	12
Total	7	14	0	21

7. Key findings

7.1 Analysis of grievance and appeal cases indicated that there was no significant difference in cases by ethnicity, gender or disability. Reasons recorded for grievances and appeals did not indicate any pattern of discrimination against staff with a protected characteristic.

7.2 Analysis of redundancy cases indicated that there was no significant difference or pattern of discrimination against staff with a protected characteristic. Redundancies were as a result of a directorate organisational change programme and included a number of different roles in different geographical locations.

7.3 In response to bullying and harassment themes raised through ER cases and organisation wide activities such as staff surveys, examples of action PHE have taken include;

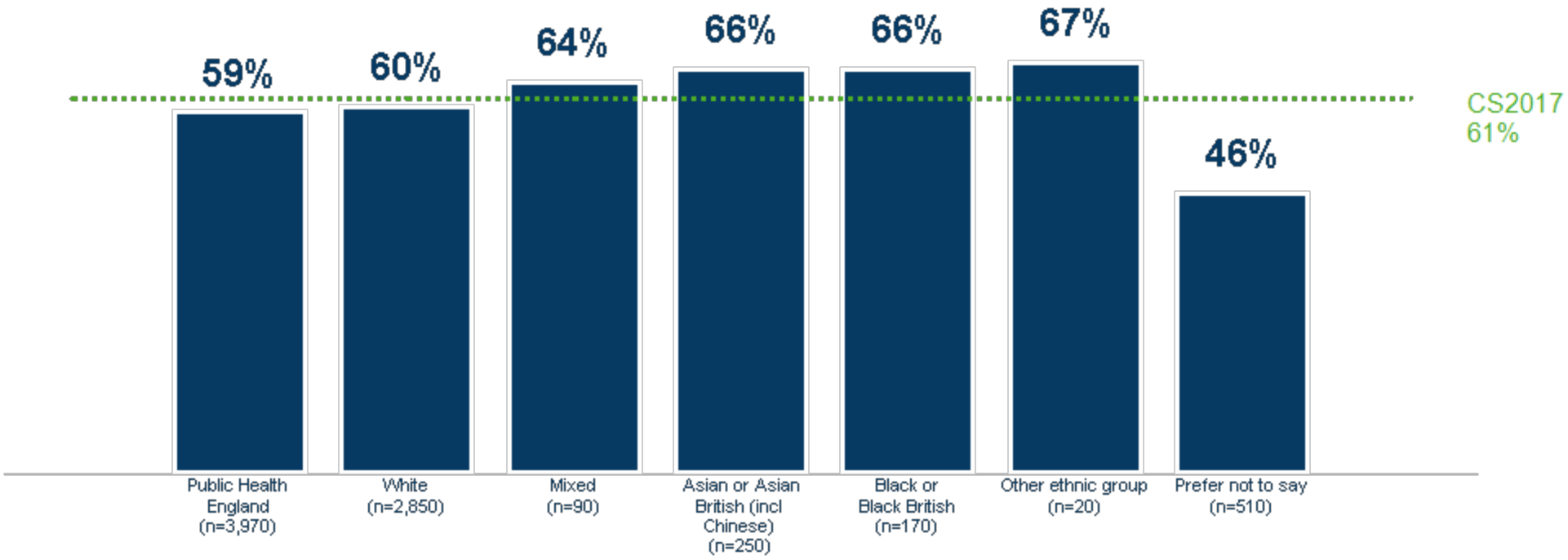
6.2.1 PHE undertook a Bullying and Harassment Survey in 2017 to gain a better understanding of the detail behind the main PHE staff survey bullying and harassment scores. As a result of the additional survey an action plan was launched in April 2018. The principal elements of the plan are:

- clear leadership and role modelling from the chief executive and the senior leadership team that tackling inappropriate behaviour is a priority for PHE and that there is zero tolerance of bullying and harassment
- training for all staff, including the senior leadership team, and workshops on what constitutes inappropriate behaviour and what to do about it
- appointment of independent Respect Guardians
- clear flow chart to outline the process for dealing with bullying and harassment and where to go for support
- development and wider promotion of our own PHE internal mediation service and the CS mediation service
- further investigation and intervention as appropriate in teams that demonstrated higher than average levels the staff survey
- delivery of an improved offer on resilience/how to deal with stress

6.2.2 Pay related to terms and conditions was also included in the action plan. Lead negotiations with Department of Health and Social Care and Her Majesty's Treasury for a new, sustainable pay system for the least well paid staff to secure their recruitment and retention and to act as pilot organisation as part of a Civil Service wide programme with the aim of developing and testing "what works" to increase headline annual pay awards from 1% to a higher level. A plan is currently being devised to help clarify the extent of non-pay rewards that are available to PHE staff. This will ensure that there is a better understanding of PHE's full reward package

ENGAGEMENT BY ETHNICITY

Commentary text can be added here



Please note that groups with fewer than ten respondents will not be displayed

Public Health England

2017

ENGAGEMENT QUESTIONS BY ETHNICITY

Scores in the table below are % positive

10% points or more above PHE Overall

10% points or more below PHE Overall

Within 10% points of PHE Overall

	Public Health England (n=3,970)	White (n=2,850)	Mixed (n=90)	Asian or Asian British (incl Chinese) (n=250)	Black or Black British (n=170)	Other ethnic group (n=20)	Prefer not to say (n=510)
Engagement Index	59%	60%	64%	66%	66%	67%	46%
B47. I am proud when I tell others I am part of PHE	62%	63%	74%	74%	78%	83%	44%
B48. I would recommend PHE as a great place to work	52%	54%	67%	67%	66%	65%	30%
B49. I feel a strong personal attachment to PHE	41%	42%	41%	54%	48%	57%	27%
B50. PHE inspires me to do the best in my job	44%	45%	57%	56%	59%	52%	27%
B51. PHE motivates me to help it achieve its objectives	41%	43%	47%	54%	55%	57%	24%

Please note that groups with fewer than ten respondents will not be displayed

Public Health England

MY WORK QUESTIONS BY ETHNICITY

Scores in the table below are % positive

10% points or more above PHE Overall

10% points or more below PHE Overall

Within 10% points of PHE Overall

	Public Health England (n=3,970)	White (n=2,850)	Mixed (n=90)	Asian or Asian British (incl Chinese) (n=250)	Black or Black British (n=170)	Other ethnic group (n=20)	Prefer not to say (n=510)
Theme: My work	78%	80%	75%	78%	78%	72%	68%
B01. I am interested in my work	92%	93%	90%	93%	93%	83%	89%
B02. I am sufficiently challenged by my work	80%	82%	66%	80%	79%	63%	72%
B03. My work gives me a sense of personal accomplishment	79%	81%	73%	81%	79%	67%	70%
B04. I feel involved in the decisions that affect my work	62%	66%	64%	60%	66%	63%	44%
B05. I have a choice in deciding how I do my work	78%	80%	81%	77%	73%	83%	63%

Please note that groups with fewer than ten respondents will not be displayed

Public Health England

ORGANISATIONAL OBJECTIVES AND PURPOSE QUESTIONS BY ETHNICITY

Scores in the table below are % positive

10% points or more above PHE Overall

10% points or more below PHE Overall

Within 10% points of PHE Overall

	Public Health England (n=3,970)	White (n=2,850)	Mixed (n=90)	Asian or Asian British (incl Chinese) (n=250)	Black or Black British (n=170)	Other ethnic group (n=20)	Prefer not to say (n=510)
Theme: Organisational objectives and purpose	76%	78%	80%	81%	82%	75%	65%
B06. I have a clear understanding of PHE's objectives	77%	79%	80%	80%	81%	75%	65%
B07. I understand how my work contributes to PHE's objectives	76%	77%	80%	82%	82%	75%	65%

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Public Health England

MY MANAGER QUESTIONS BY ETHNICITY

Scores in the table below are % positive

10% points or more above PHE Overall

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Within 10% points of PHE Overall

	Public Health England (n=3,970)	White (n=2,850)	Mixed (n=90)	Asian or Asian British (incl Chinese) (n=250)	Black or Black British (n=170)	Other ethnic group (n=20)	Prefer not to say (n=510)
Theme: My manager	69%	71%	75%	72%	71%	71%	53%
B08. My manager motivates me to be more effective in my job	70%	72%	77%	73%	73%	71%	53%
B09. My manager is considerate of my life outside work	83%	86%	89%	85%	82%	79%	66%
B10. My manager is open to my ideas	82%	85%	82%	78%	84%	87%	66%
B11. My manager helps me to understand how I contribute to PHE's objectives	61%	63%	72%	67%	66%	67%	45%
B12. Overall, I have confidence in the decisions made by my manager	75%	78%	84%	75%	75%	79%	57%

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MY MANAGER QUESTIONS BY ETHNICITY

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Theme: My manager	69%	71%	75%	72%	71%	71%	53%
B13. My manager recognises when I have done my job well	80%	82%	79%	83%	79%	75%	63%
B14. I receive regular feedback on my performance	68%	70%	75%	71%	70%	63%	53%
B15. The feedback I receive helps me to improve my performance	65%	67%	74%	71%	69%	67%	48%
B16. I think that my performance is evaluated fairly	71%	74%	79%	76%	66%	71%	50%
B17. Poor performance is dealt with effectively in my team	37%	38%	43%	43%	42%	50%	27%

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Public Health England

MY TEAM QUESTIONS BY ETHNICITY

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Theme: My team	80%	82%	79%	81%	85%	82%	68%
B18. The people in my team can be relied upon to help when things get difficult in my job	83%	86%	86%	82%	86%	88%	70%
B19. The people in my team work together to find ways to improve the service we provide	81%	83%	81%	83%	87%	83%	71%
B20. The people in my team are encouraged to come up with new and better ways of doing things	76%	78%	70%	79%	82%	75%	63%

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Public Health England

LEARNING AND DEVELOPMENT QUESTIONS BY ETHNICITY

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Theme: Learning and development	52%	54%	56%	56%	58%	52%	36%
B21. I am able to access the right learning and development opportunities when I need to	65%	68%	59%	68%	70%	58%	47%
B22. Learning and development activities I have completed in the past 12 months have helped to improve my performance	54%	56%	60%	58%	57%	54%	43%
B23. There are opportunities for me to develop my career in PHE	40%	42%	52%	44%	51%	46%	25%
B24. Learning and development activities I have completed while working for PHE are helping me to develop my career	47%	49%	54%	55%	55%	50%	30%

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Public Health England

INCLUSION AND FAIR TREATMENT QUESTIONS BY ETHNICITY

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Theme: Inclusion and fair treatment	79%	82%	85%	79%	76%	78%	61%
B25. I am treated fairly at work	81%	85%	88%	78%	78%	79%	61%
B26. I am treated with respect by the people I work with	84%	87%	90%	84%	79%	88%	71%
B27. I feel valued for the work I do	70%	73%	80%	76%	71%	63%	53%
B28. I think that PHE respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc)	79%	83%	84%	80%	74%	83%	58%

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Public Health England

RESOURCES AND WORKLOAD QUESTIONS BY ETHNICITY

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Theme: Resources and workload	73%	75%	75%	79%	76%	74%	61%
B29. I get the information I need to do my job well	72%	74%	75%	80%	77%	83%	55%
B30. I have clear work objectives	79%	81%	81%	84%	82%	83%	66%
B31. I have the skills I need to do my job effectively	90%	92%	92%	89%	91%	92%	82%
B32. I have the tools I need to do my job effectively	72%	74%	72%	80%	78%	63%	60%
B33. I have an acceptable workload	60%	62%	61%	70%	62%	67%	47%

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Public Health England

RESOURCES AND WORKLOAD QUESTIONS BY ETHNICITY

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Theme: Resources and workload	73%	75%	75%	79%	76%	74%	61%
B34. I achieve a good balance between my work life and my private life	67%	70%	67%	70%	68%	58%	54%

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Public Health England

PAY AND BENEFITS QUESTIONS BY ETHNICITY

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Theme: Pay and benefits	38%	42%	34%	31%	31%	28%	22%
B35. I feel that my pay adequately reflects my performance	40%	45%	33%	35%	37%	26%	24%
B36. I am satisfied with the total benefits package	37%	42%	38%	32%	27%	30%	20%
B37. Compared to people doing a similar job in other organisations I feel my pay is reasonable	36%	40%	31%	26%	31%	26%	22%

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Public Health England

LEADERSHIP AND MANAGING CHANGE QUESTIONS BY ETHNICITY

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Theme: Leadership and managing change	42%	44%	46%	45%	51%	44%	25%
B38. Senior managers (Deputy Directors and above) in PHE are sufficiently visible	50%	52%	60%	56%	61%	42%	33%
B39. I believe the actions of senior managers (deputy directors and above) are consistent with PHE's values	47%	50%	59%	51%	55%	54%	28%
B40. I believe that the Leadership Team in PHE have a clear vision for the future of PHE	43%	45%	49%	49%	51%	43%	28%
B41. Overall, I have confidence in the decisions made by PHE's senior managers (deputy directors and above)	42%	46%	45%	46%	50%	48%	23%
B42. I feel that change is managed well in PHE	27%	28%	32%	33%	42%	30%	15%

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Public Health England

TAKING ACTION QUESTIONS BY ETHNICITY

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Theme: Taking action	46%	49%	46%	44%	51%	43%	26%
B52. I believe that senior managers (deputy directors and above) in PHE will take action on the results from this survey	50%	54%	50%	47%	57%	43%	28%
B53. Where I work, I think effective action has been taken on the results of the last survey	42%	45%	43%	40%	45%	43%	24%

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Public Health England

ORGANISATIONAL CULTURE QUESTIONS BY ETHNICITY

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Theme: Organisational culture	74%	77%	75%	73%	71%	74%	56%
B54. I am trusted to carry out my job effectively	90%	91%	94%	94%	90%	92%	81%
B55. I believe I would be supported if I try a new idea, even if it may not work	72%	76%	73%	70%	65%	63%	52%
B56. In PHE, people are encouraged to speak up when they identify a serious policy or delivery risk	67%	71%	64%	67%	68%	65%	47%
B57. I feel able to challenge inappropriate behaviour in the workplace	61%	64%	61%	59%	56%	78%	44%
B58. PHE is committed to creating a diverse and inclusive workplace	77%	82%	82%	75%	76%	74%	56%

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LEADERSHIP STATEMENT QUESTIONS BY ETHNICITY

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Theme: Leadership statement	55%	58%	61%	57%	62%	60%	36%
B59. Senior managers (Deputy Directors and above) in PHE actively role model the behaviours set out in the Civil Service Leadership Statement	43%	46%	48%	44%	53%	43%	25%
B60. My manager actively role models the behaviours set out in the Civil Service Leadership Statement	67%	70%	75%	69%	71%	75%	46%

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Public Health England

CIVIL SERVICE VISION QUESTIONS BY ETHNICITY

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Theme: Civil Service vision	27%	26%	33%	41%	37%	41%	26%
B61. I am aware of the Civil Service vision for 'A Brilliant Civil Service'	29%	28%	36%	43%	36%	43%	29%
B62. I understand how my work contributes to helping us become 'A Brilliant Civil Service'	25%	24%	31%	39%	38%	39%	22%

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WELLBEING QUESTIONS BY ETHNICITY

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Theme: Wellbeing	64%	66%	66%	64%	68%	64%	55%
W01. Overall, how satisfied are you with your life nowadays?	67%	70%	67%	67%	68%	65%	56%
W02. Overall, to what extent do you feel that the things you do in your life are worthwhile?	74%	76%	70%	76%	76%	74%	64%
W03. Overall, how happy did you feel yesterday?	64%	65%	66%	69%	70%	65%	54%
W04. Overall, how anxious did you feel yesterday?	50%	51%	59%	46%	58%	52%	45%

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For questions W01, W02 and W03 the percent positive is the proportion answering 7, 8, 9 or 10 to each question.
For question W04 the percent positive is the proportion answering 0, 1, 2 or 3 to the question.

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