Written evidence submitted by Our Concern Our NHS, Doctors Association UK, Pakistani Physicians of Northern Europe (APPNE), Association of Physicians & Surgeons UK (APPSUK), British Association of Physicians of Indian Origin (BAPIO), British Egyptian Medical, Association (BEMA), British International Doctors Association (BIDA), British Islamic Medical Association (BIMA), Doctors for the NHS, Every Doctor (NHL0050)

Establish independent scrutiny panels in each hospital

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Summary

This paper is presented on behalf of sixteen medical organisations who care passionately about the NHS and are seeking change in the current disciplinary processes that NHS staff are subject to. These of course are led by senior managers within our hospitals and other health institutions.

Maintaining High Professional Standards in the Modern NHS (MHPS) [1] is a framework for the handling of concerns about doctors and dentists in the NHS in England. Recognising that unfair proceedings have wide implications, MHPS was introduced in 2005 to tackle the blame and suspension culture. NHS Employers collaborating with the BMA wanted a framework that would guide disciplinary proceedings, minimising suspension, and the involvement of lawyers. Regrettably, these objectives have not materialised as intended. Sir Robert Francis in his 'Freedom to Speak Up' [2] review criticised the use of disciplinary procedures by NHS Trusts (Trust) saying, '*employers often felt challenged in how to separate safety concerns from disciplinary issues'*. Guidance on the appropriateness of disciplinary action in the form of 'A Just Culture Guide', has not improved practice [3]. An imbalance in the workforce in relation to bias in disciplinary action has long been recognised and ambitions to correct this set out [4,5]. Recent events in the Countess of Chester Hospital and other high-profile cases highlight the ongoing failure of those in management positions in our NHS Trusts to be relied on to act appropriately when patient safety concerns are raised by staff members.

Data is available that shows that the cost to the NHS of pursuing these proceedings is unknown, unaudited and unregulated. As a result, no learning or best practice models exist. Investigation is not only hugely stressful for the individual member of staff but impacts on their immediate colleagues and members of the wider institution. These negative effects would further impinge on patient care and safety. Current industrial action by doctors is seeking better working conditions, a better culture, not just asking for more pay but for better management. NHS staff want to feel safe in their workplace and have confidence in management structures, when reporting concerns and disciplinary proceedings.

It is of great concern that despite many catastrophes over the past thirty years, the changes introduced to address them, including the Kark Review, have been largely non-statutory. This has resulted in avoidable harm to the public and to staff raising concerns. Each acknowledgement is followed by a statement that lessons have been learnt!

Without meaningful change, the press will continue to headline with cases like those sad examples witnessed over recent years in Chester and Birmingham and many more. **We believe that the only way to address behaviour is the introduction of a LAW to drive the changes that will support staff expressing their concerns, and faith in their hospital management. The relevance of a law in**

changing behaviour and culture is shown by its effects on wearing seat belts and smoking amongst many others.

Our proposal seeks to establish independent **Scrutiny Panels** with **powers set out by statute** in each hospital, from which management would have to seek permission **before** undertaking any investigatory or disciplinary action against staff. The panel could also function as the local guardians for Freedom To Speak Up for each hospital, synergistic with the Protection for Whistleblowers Bill currently making its way through Parliament that calls for the introduction of an independent Office of the Whistleblower. The establishment of scrutiny panels would make an immediate and palpable improvement of the current corrosive culture of fear confronting staff across all disciplines in Hospitals.
It should go without saying that all disciplinary action should follow the principles of natural justice; those are **'***Adequate notice, a fair hearing, and the absence of bias.'*

The Case for Change

Freedom of Information requests were sent to all English NHS Trusts in February 2021 with questions relating to their MHPS activity: number of concerns, full investigations, outcomes and ethnicity and gender of the doctors involved. None of the 140 Trusts approached submitted complete data. (See Table 1)

Response to FOI	Number of Trusts
No response	10
Responses from Trusts with data to analyse	73
Data not provided:	57 breakdown below
Confidentiality compromised by low number data*	30
Data refused on cost basis*	14
Data refused as low priority	1
Data analysis still in progress**	12

Table 1: Response to FOI requests regarding Trust MHPS activity between 2015-2020. * Allowed under FOI exclusions.

**allowed under FOI exemption (s40)*

*** 9 months after original request, FOI gives 20-day deadline*

Thirty Trusts declined to provide data on the grounds that low numbers would lead to identification of individuals. Confidentiality is important but we do not accept that this is a reasonable response and argue that this data should be available in the public domain.

The significant number of incomplete responses, refusals and non-responders suggest that most Trusts, despite the requirement in MHPS, keep no readily available records. It is manifestly clear therefore that Trusts have no mechanism to audit their MHPS activity, MHPS outcomes, and as such, there is an absence of accountability and transparency in relation to disciplinary action against doctors and the recording of the decisions.

Financial costs of MHPS investigations and outcomes were also requested. Only one Trust provided financial data and stated that internal staffing costs related to MHPS activity ran into several hundred thousand pounds. Doctors who have been subjected to these processes report eye

wateringly high costs accrued by individual Trusts. These sums range from tens of thousands to millions of pounds. The evidence quoted arises from personal communications between the parties and reports available from open data sources. These costs are borne by individual Trusts, but nonetheless paid from the NHS purse, therefore thetaxpayer. MHPS rules require the cost of investigating doctors to be recorded and audited; this is clearly nothappening.

BAME data was also requested from Trusts. The mean percentage of BAME doctors from all Trusts was 42% (10-79%). The proportion of BAME doctors subject to MHPS investigation was not calculated. Not all Trusts provided this data, the analysis therefore somewhat limited. Row 2 of the table gives the number of responses where Trusts provided sufficient BAME data for analysis (Table 2). For the most part this was incredibly low. FOI request for MHPS Trust activity, suitable for analysis, clearly demonstrated BAME doctors were overrepresented in all areas of investigation and sanction, except where health was the concern. This suggests that BAME doctors have the same level of health concerns than non-BAME doctors, but in conduct and performance they are nearly 10 to 60% more likely to be subject to a disciplinary investigation, and overall, approximately 20% more likely to be referred to the GMC or dismissed from their employment. This preponderance of BAME doctors in Trust MHPS activities, and the more severe outcomes is likely to be a gross underestimate. Bias is still very prevalent.

Table 2: Numbers and Outcomes of MHPS investigations for BAME doctors. (* = data not included in the analysis

	Type of investigation		Outcome	
	Conduct*	Capability*	Referral to GMC*	Dismissal*
Number of total doctors subject to MHPS investigation overall	910	90	100	58
From above number of completed BAME responses suitable for analysis* **	78	52	55	48
S40 response**	6	4	5	6
Data not recorded**	8	4	2	2
From*we calculated the precentageof BAME doctors in each category ***	46.5	67.25	51.1	49.2
Odds Ratio of BAME doctor subject to disciplinary activity * compared to non BAME doctor	1.11	1.6	1.22	1.17

Proposed solution

We propose that the government establish an Independent and elected Scrutiny Panel with full statutory powers in each hospital. Management would have to seek permission from this Panel before embarking on any formal investigatory process following informal enquiries in all cases.

This panel would also function as the Local Guardian for Freedom To Speak Up (FTSU) thereby providing protection to staff against any recrimination.
The changes proposed are designed to identify and **stop unfair and malicious proceedings from the outset.** This process would result in an overall reduction of formal investigations, prevent the significant negative effects on doctors and their families and significantly reduce costs and wasted

time. We believe that the introduction of the Independent Scrutiny Panel would improve trust in processes, remove bias and change culture in a positive way.

The Scrutiny Panel

1.1 Confidence in the panel would require it to be an independent body and be seen to be so. Appointed members would be at risk of being influenced by management and, understandably, would not be perceived as being independent. A more acceptable form would be if the Panel consisted of elected senior doctors and senior nurses in the majority along with fewer non-executive members of the Trust Board.

1.2 Elected members should be remunerated for the time that they spend on each case.

1.3 The form of remuneration, whether as payment or time in lieu, would be left to local agreements between the Trust and the panel member.

1.4. Panel members would be required to undergo formal training. The panel should have access to independent legal and human resource advice.

Functions and responsibilities of the Panel

2.1 The Panel would need to consist of elected senior doctors, senior nurses, and non-executive membersof the Board.

2.2 The Panel would elect a chair and a co-chair.

2.3 The Panel would receive and adjudicate applications, which would have to be received in writing. The applications to the panel would follow a protocol setting out the allegations, evidence and any mitigation stating what action had been taken, if any, to address the matter with the staff concerned. The request should also clearly set out why such proceedings are appropriate and justified and include reference to all rules and governing principles. Similar principles would also apply to any member of staff raising a concern.

2.4 The Panel considering an initial application would consist of at least two doctors, a senior nurse, and a non-executive member selected by the chair.

2.5 The Panel would ensure that any formal investigatory process or action was appropriate, justified, and free from bias.

2.6 The decision of the Panel will be given verbally and in writing within 48 hours.

2.7 There should be a right of appeal for both the doctor and the Trust (cf para 3).

2.8 The Progress of formal investigations should be reported to this Panel at each stage, and at least monthly including costs incurred. The Panel would have the power to seek clarification or raise concerns at any stage if they felt actions were unjustified, flawed, or incorrect**.**

2.9 .a The panel should be open to receipt of information given voluntarily by any member of staff,including information that they may wish to give in confidence.

2.9.b Should the panel decide to consider the contents of the information, it should divulge the information, maintaining the anonymity of the informant if applicable, to the Trust as well as to the doctor.

2.9.c Should the panel reject the information; it should direct the informant to an appropriate department orindividual.

2.10 Receipt of such information and details about what action was taken must be recorded in full.

2.11 On conclusion of formal proceedings, the decisions of the Trust management should also be submitted to the Panel. The Panel should scrutinise the management decisions and outcomes, to ensure natural justice had been applied and decisions and sanctions were appropriate, proportionate, and justified.

2.12 On completion of the process the Trust will submit audited costs for the investigation for review by thePanel.

2.13 The Panel will ensure that annual audits of MHPS or other disciplinary activity, costs and outcome are carried out andreported publicly in an anonymised format.

2.14 At all times, the Panel should ensure they have followed MHPS guidance and the principles of naturaljustice.

2.15 The Panel would be required to provide quarterly reports to the Trust Board and annual reports toNHS England.

Appeal against the initial Scrutiny Panel judgement (cf para 2.7)

3.1 In case of a dispute between management and the panel relating to a decision to proceed or not with an investigation, management should submit a written appeal to the Chair, who would then form a larger panel consisting of at least three doctors, a senior nurse and two non-executive members. This appeal should be addressed within two weeks of receipt.

Panel and management etiquette

4.1 All verbal and written communications between the Trust, the Panel and external bodies should berecorded and be available for review at any time by authorised persons.

4.2 The Trust should ensure that all doctors are aware of the presence of the Scrutiny Panel and itsmembers using an agreed communications strategy.

4.3 Management should not engage in any informal discussion with any member of the Panel.

Election to the Scrutiny Panel to be conducted by HR

5.1 Notice of an election and invitation for nomination of candidates to the Trust's Independent ScrutinyPanel should be properly advertised to all doctors and nurses.

5.2 Nominations should be submitted to HR within 14 days after the posting of the notice.

5.3 Each nomination should state the name of the candidate and be supported by two doctors or nursesas appropriate.

5.4 Election would be by secret ballot.

5.5 The electoral process for non-executive members would follow a similar process.

5.6 Panel members would be elected for a term not exceeding three years.

5.7 Number to be elected
Senior doctors – 7
Senior nurses - 4
Non-executive members - 3

Eligibility of doctors and senior nurses to stand for election

6.1 To be eligible for election Panel members cannot hold or have held any Trust managerial responsibilities in the three years prior to the election.

6.2 Retired individuals would be eligible, subject to above constraint.

6.3 Panel members must agree to receive appropriate training.

6.4.a Panel members must agree and sign a confidentiality agreement confirming that they will not discussany case informally with members of management or other staff.

6.4.b A breach of 6.4.a will result in the immediate termination of the membership of the panel and mayattract disciplinary proceedings.

6.4 Panel members would be entitled to stand for election for two further terms to encourage continuity.

6.6 Any Panel member who, during their term, accepts a Trust managerial responsibility would be required to stand down from the Panel. In these circumstances, and when a vacancy arises, instead of holding another election, the medical and nursing members of the Panel would invite a suitable candidate to substitute for the current term of that member

Eligibility of non-executive members

7.1 They must agree to receive appropriate training.

7.2 They would be entitled to serve for two more terms.

Supportive structure

8.2 The Panel would be supported by a nominated secretary who should also update the availability ofmembers.

8.2 The Panel will be provided with a nominated room.

8.3 The Office should have access to telephone and IT facilities as routinely provided to doctors.

8.4 Contact details of the secretary and the chair should be easily accessible.

8.5 The process should be supported financially by NHS England, not by some other government fund.This is essentially NHS business.

Conclusions

Changes made to the investigation and disciplinary process of doctors have failed to prevent increasing instances of unfair, biased, and malicious proceedings. Natural justice has not prevailed. The proposals made in this paper serve to rebalance the current situation by establishing an independent and elected statutory Scrutiny Panel in each Trust.

Currently there is no meaningful process in place to monitor and audit disciplinary proceedings and their outcomes. There is no record or audit of monetary costs.

While doctors have been penalised when found to be guilty Trusts have rarely been subjected to any form of scrutiny or disciplinary action when their actions may have been incorrect or misplaced. This issue requires further consideration.

It is envisaged that, should the principle in the proposals be adopted, the system could be rolled out to primary care, the nursing profession, allied health professionals and other members of staff. It is also our expectation that these proposals would be adopted by all devolved nations**.**

While we agree that there is room to improve the regulation of medical managers, following the absence of accountability of those overseeing concerns in the Letby case we believe that a knee jerk response could mask the underlying and complex cultural issues and could be just another retrospective move that would do nothing to help control the initial stages of investigating staff. Simply put, regulations of this type come into action too late - shutting the stable door after the horse has bolted.

In summarising our proposals, emphasising that the first responsibility of every doctor is to do no harm, the overarching objective of the Independent Scrutiny Panel is to protect the public interest which includes ensuring that everyone involved in the Trust act in and put the public interest first.

We welcome and support plans for the introduction of the Office of the Whistleblower currently goingthrough Parliament [6].

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