Policy for Managing Performance of Medical & Dental staff

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Purpose of Agreement	This policy outlines the procedures to be followed when managing the performance of Medical and Dental Employees
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Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date

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Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
1	10/03/2022	People Partnering	Policy Steering Group, Clinical Executive Meeting	Policy re-write.

SUMMARY OF POLICY

This policy outlines the procedures to be followed when managing the performance of Medical and Dental Employees and now including the new just culture guide supporting consistent, constructive, and fair evaluation of the actions of staff involved in patient safety incidents.

Please note: A just culture guide is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.

This policy has been written with focus to ensure it is as concise and as accessible as possible whilst not diverging substantially from the national framework.

The emphasis is on early resolution routes, is more user friendly, with a change to the language and tone of the policy, with the aim of making this more inclusive and easier to follow. The emphasis is on a compassionate, values based and person-centred approach in line with Solent NHS Trust values *and the recommendations set out in the letter to NHS CEO's and Chairs of 24 May 2019 from Dido Harding "Learning lessons to improve our people practices"*.

What it is:

An approach to resolving performance related concerns, aligned to our values that supports an open and honest environment in which workplace issues are talked through, addressed, and resolved at the earliest opportunity. This should include the aim to ensure the Practitioner does not feel in any way 'abandoned', unsupported, or devalued by the Trust during what is likely to be a period of uncertainty and personal anxiety'. It outlines a more positively focused approach to resolving workplace issues, that depends on the circumstances of the situation.

Supporting our values is the use of the just culture guide, which can be used by all parties to explain how they will respond to incidents, as a reference point for organisational Human Resources and the incident reporting, investigation and learning policy and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made.

As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

A just culture guide does not replace HR advice and should be used in conjunction with organisational policy.

Where to go for further information:

- The policy should be read alongside the Improving and Managing Conduct Policy.
- Reference should also be made, when applicable, to the Improving & Managing Conduct Standard Operating Procedure and Appeals Standard Operating Procedure.
- Reference should also be made, when applicable, to the Managing Absence and Wellbeing Policy.

- Reference should also be made to Appendix 1, when applicable, to the Equality Impact Assessment
- Reference should also be made to Appendix 2, when applicable, for Manager support on the just culture guide.

Policy for Managing Performance of Medical and Dental Employees

Contents

1. General Principles Applicable to These Procedures

Scope and Definitions

1.1 This policy applies to permanent, locum and fixed term contract employees employed under the Medical and Dental terms that hold a contract of employment or engagement with the Trust, in line with Solent NHS Trust's Equality, Diversity, Inclusion and Human Rights Policy.

1.2 In line with Trust policy, equality and human rights impact assessment has been completed and no significant issues have been identified. It is understood that no employee will receive less favourable treatment on the grounds of disability, age, sex, race, religion or belief, gender reassignment, pregnancy or maternity, marriage or civil partnership, working patterns or Trade Union membership or non-membership in relation to the application of this policy. The equality and human rights impact assessment is included at Appendix 1. This policy has also been assessed and meets the requirements of the Mental Capacity Act 2005.

Status of these Procedures

1.3 These procedures have been adopted following consultation with the Policy Steering Group, Trust Executive Team, Clinical Executive Group and the Doctors and Dentists Negotiating Committee and apply to all medical and dental staff ("Practitioners") employed by Solent NHS Trust (the "Trust").

1.4 These procedures govern the way that the Trust will deal with matters of conduct and capability or ill-health relating to medical or dental staff. They are based on, and clarify the Trust's approach to, the national Maintaining High Professional Standards framework ("MHPS"). Therefore, in the event of any perceived conflict, the national procedures will prevail.

Supporting the Practitioner

1.5 The Practitioner's health and wellbeing will be considered at all stages of these procedures, as will support via the Trust's Employee Assistance Programme. Advice should be sought from Occupational Health to determine how to reasonably mitigate any disadvantage that a Practitioner might suffer due to a health condition under these procedures.

Confidentiality

1.6 The Trust will keep the details of cases, investigations or hearings under these procedures confidential, save where it is reasonable for the Case Manager or Case Investigator, or other managers properly involved in these procedures to disclose such information in order to progress these procedures or in the interests of public safety.

1.7 No press notice should be issued, nor should the name of the Practitioner be released to the press regarding any investigation or hearing. The Trust will only confirm that an investigation or hearing is underway.

1.8 Practitioners and any other Trust employees should also maintain the confidentiality of cases, investigations, or hearings under these procedures.

Work with other Organisations, Referrals to Regulators and Alert Letters

1.9 These procedures are not intended to address concerns about the fact that a Practitioner has been suspended from practice by their regulator (which may separately require the Trust to consider whether it is sustainable to continue to employ the Practitioner, particularly if that suspension is for more than a period of 5 months). The duty to protect patients is paramount. If a Practitioner has been excluded or had restrictions placed on his or her practice under these procedures, the Practitioner must:

1.9.1 inform the Case Manager of any other organisation(s) with whom he or she undertakes voluntary or paid work.

1.9.2 seek the Case Manager's consent to continue any such work; and

1.9.3 agree not to undertake any work in the affected area of practice with any other organisation, without the Case Manager's consent.

1.10 If, at any time, the Case Manager considers that a Practitioner could be a serious potential danger to patients or staff, or is practising in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, the Case Manager will:

1.10.2 refer the Practitioner to his or her relevant regulatory body; and/or

1.10.3 consider whether an alert letter should be issued; and/or

1.10.4 inform other individual relevant organisations of any restriction on practice or exclusion and provide a summary of the reasons for this.

Practitioner Performance Advice ("PPA")

1.11 Practitioner Performance Advice (formerly the National Clinical Assessment Service, NCAS) was established in 2001 to provide expertise to the NHS on resolving concerns fairly, share learning for improvement and preserve resources for patient care. At any stage of a case under these procedures' consideration should be given to whether to contact, seek the advice of and/or otherwise involve PPA. This includes seeking telephone advice, supported local case management, clinical performance assessment, and support in implementing recommendations arising from assessment.

1.12 A Practitioner undergoing PPA assessment must co-operate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the assessment is complete.

1.13 A failure by a Practitioner to co-operate with a referral to PPA may be seen as evidence of a lack of willingness by the Practitioner to work with the Trust to resolve concerns. This may necessitate disciplinary action and consideration of referral to the GMC or GDC. Potential or alleged performance issues are not proven at this stage.

The Right to be Accompanied

1.14 At a conduct or capability hearing or investigatory interview relating to a Practitioner (including under the Trust's Improving and Managing Conduct Policy and Procedure), the Practitioner may be accompanied by a companion or representative or dental protection support.

1.15 The Practitioner's companion or representative may be a workplace colleague, or a trade union representative, or dental protection support, not acting in a legal capacity. In a hearing, a companion or representative will be entitled to present a case on behalf of the Practitioner, address the panel and question the management case and any witness evidence.

1.16 It is the Practitioner's responsibility to arrange any companion or representative that they wish to attend a meeting or hearings under a capability or conduct procedure and to ensure that they are able to attend at the relevant place, date and time. Non-availability of a companion or representative should not be permitted to substantially delay such procedures. Meetings or hearings should only be postponed due to a companion's or representative's non-availability if they can be re-arranged at a mutually convenient date within a reasonable timeframe.

Termination of Employment with Misconduct or Capability Issues Unresolved

1.17 In all cases where a Practitioner leaves employment before the conclusion of misconduct or capability procedures, these procedures must be taken to a final conclusion and any appropriate action must be taken (such as referrals to a professional body, the Disclosure and Barring Service or an alert letter), irrespective of the Practitioner's personal circumstances.

1.18 Every reasonable effort must be made to ensure the Practitioner remains involved in the process, by seeking to contact them with any known contact details.

2 First Steps Where Any Concern Arises

Informal Resolution and Fact-Finding

2.1 The management of performance is a continuous process which is intended to identify any problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to formal procedures. The Trust accepts that breaches of the rules of conduct and standards of performance will occur from time to time. Wherever possible, these should be dealt with informally in the first instance. As a general principle, it is expected that the immediate clinical line manager of the practitioner will deal with issues of minor misconduct or performance (if necessary, with HR support) without resort to the Chief Medical Officer (CMO) and formal processes. In such circumstances, it may or may not be appropriate for the CMO to be informed of the outcome

2.2 It should therefore be possible to informally resolve most concerns (unless they are serious or present a clear risk to patient or staff safety or the Trust's services) about a Practitioner's conduct, capability, or health. Where appropriate managers should consult with the People Partner as to options to support the Practitioner, which may include (non-exhaustively):

2.2.1 Informal discussions between the Manager and the Practitioner to ensure awareness.

2.2.2 Additional supervision arrangements.

2.2.3 Mentoring or buddying.

2.2.4 Team/ facilitation or mediation.

2.2.5 Sickness absence or health related support, such as an Occupational Health referral, for the investigation of specific health problems.

2.2.6 A temporary behavioural agreement, or agreed undertakings; or

2.2.7 Where there are capability concerns, agreeing an action plan with the Practitioner with the advice of PPA, or an agreed referral of the Practitioner to PPA for assessment.

Where escalation may be needed, this should be discussed with the Clinical Director or Lead Clinician then with the Chief Medical Officer. Where some degree of investigation might be required, this can normally be carried out by way of an informal "fact-finding" exercise by line managers with the aim of either achieving an early resolution, or to determine that the concerns are serious enough to engage the procedures set out below. Fact-finding should be carried out with reasonable regard to the Practitioner's confidentiality and follow the just culture guide which highlights important principles that need to be considered before formal

management action is directed at an individual staff member, such as creating a culture of openness and honesty, understanding the context, looking at the wider picture, listening, learning and improving. A just culture guide can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.

Consideration of Restrictions on Practice or Exclusion

2.3 Where potentially serious concerns are raised at the outset or at any stage of these procedures, the Trust must urgently consider whether it is necessary and proportionate to:

2.3.1 place temporary restrictions, amendments, or requirements for supervision on the Practitioner's practice.

2.3.2 impose an immediate exclusion under paragraph 3.5 pending further investigation; or

2.3.3 impose a formal exclusion under paragraph 3.8.

Appointment and the roles of the Case Manager and Non-Executive Member

2.4 Where a concern about the conduct, performance or ill-health of a Practitioner is raised, the Chief Executive will be notified, and a Case Manager will be appointed. The Case Manager will be the Chief Medical Officer or an Associate Medical Officer or Clinical Director to whom the role has been delegated by the Chief Medical Officer. The first task of the Case Manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal investigation and/or formal conduct procedures. The Just Culture Guide (Appendix 2) must be used as part of the decision-making process. This checklist should be completed by following a discussion with the line manager who will then share their findings with the Case Manager. The Case Manager will then decide whether an informal an alternative approach can still be taken to address the problem can be adopted , or whether to enact the formal process and will consult with Chief People Officer, the Chief Medical Officer and the PPA who will then liaise with the . The PPA in the first instance as asks they ask that the first approach to them should be made by the Chief Executive or Chief Medical Officer.

2.5 The Case Manager will decide how to progress the case in accordance with these procedures. The Trust has also convened a Responsible Officer Advisory Group (constituting a sub-group of the Medical Director/Responsible Officer, a Non-executive director, the Director of Medical Education, the Dental Appraisal Lead, the Medical Appraisal Lead, an Associate Medical Officer, a Revalidation Manager and

the Chief People Officer/People Lead and a Lay Member), which may provide support and advice to the Case Manager in dealing with cases under these procedures, although the ownership of decisions will remain with the Case Manager.

2.6 In order for the Case Manager to determine the most appropriate approach, the Case Manager should explore the potential problem with the PPA to consider different ways of tackling it, possibly recognising the problem as being more to do with work systems than practitioner performance, or see a wider problem needing the involvement of an outside body other than the PPA e.g., Royal Colleges, Professional Mediator/Coaching, a supported secondment. This may include a formal clinical performance assessment where all parties agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps.

The Case Manager should not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of incidents should be conducted as these frequently show that causes are more broadly based and can be attributed to systems or organisational failures or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions. The Trust actively promotes an open and fair culture, which encourages practitioners and other NHS staff to report incidents and near misses.

2.7 In the event this is formal, a Non-Executive Member will be designated by the Chairman of the Board in each case. The role of the Non-Executive member is to oversee the case and ensure that momentum is maintained. This may include:

2.7.1 Seeking assurance from the Case Manager that this policy is being reasonably applied, for example, that:

2.7.1.1 any investigation is being progressed in a timely manner.

2.7.1.2 the Practitioner is being kept informed of progress.

2.7.1.3 any restriction of duties, or exclusion is proportionate and for no longer duration than is reasonable; and

2.7.1.4 the Practitioner's health and wellbeing is always being considered and appropriate support is being provided to them.

2.7.1.5 reports regarding the continuation of any exclusion from work of the Practitioner and monitoring and reviewing the continuation of the exclusion.

2.7.2 Considering any representations from the Practitioner about the application of this policy, any investigation and/or any restriction of practice and/or exclusion.

Decision to take Informal (early resolution) or Formal Procedure

2.8 The Case Manager's first task is to:

2.8.1 identify the nature of the problem or concern.

2.8.2 assess the seriousness of the issue on the information available; and

2.8.3 assess whether the issue can be resolved through early resolution (see above) or whether it is necessary to resort to formal procedures.

2.9 To do this the Case Manager will consult with:

2.9.1 the Chief People Officer.

2.9.2 the Chief Medical Officer (where this is a separate person); and

2.9.3 PPA.

Practitioners in Training

2.10 If the Practitioner is in training, the Case Manager will also consult as soon as possible with the Postgraduate Dean about any capability or conduct concerns, as these should initially be considered as training issues. It may also be appropriate to involve the Educational Supervisor and/or college or Clinical Tutor and/or Director of Medical Education.

The Investigation Procedure

2.11 If the Case Manager decides that a formal investigation is warranted, the Case Manager will appoint an appropriately experienced or trained independent and objective Case Investigator, whose seniority will depend on the grade of the Practitioner. Those undertaking investigations must have had formal training in Equality, Diversity and Human Rights before undertaking such duties.

The Trust will ensure that investigations and conduct procedures are conducted in a way that does not discriminate on the grounds of race, colour, nationality, ethnic or national origin, or on the grounds of age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation, or trade union membership, or on any other grounds.

2.12 If it becomes clear either before or during the investigation that the case involves complex clinical issues, the Case Manager should consider inviting an independent practitioner from another NHS body to assist the Case Investigator.

2.13 The Case Manager will inform the Practitioner in writing, as soon as practicable:

2.13.1 that an investigation is to be undertaken.

2.13.2 of the name of the Case Investigator; and

2.13.3 of the specific allegations or concerns that have been raised.

2.14 The Case Investigator will carry out an unbiased investigation into the concerns and collect and document evidence to seek a balanced view and establish the relevant facts. In carrying out the investigation, the Case Investigator should:

2.14.1 give the Practitioner the opportunity, where reasonable, to see any relevant evidence relating to the case during the investigation, and a list of the people the Case Investigator will interview.

2.14.2 interview sufficient witnesses and obtain sufficient written statements to support the facts collected.

2.14.3 interview the Practitioner (who should be given the opportunity to be accompanied) and give the Practitioner the opportunity to put their view of events.

2.14.4 if a question of the clinical judgement of the Practitioner is raised, seek advice from a suitable senior medical or dental employee of the Trust, or where this is not possible, of another Trust.

2.14.5 seek to maintain the confidentiality of the investigation; and

2.14.6 if requested to, assist the Non-Executive Member to review the progress of the case.

2.15 The Case Investigator should prepare and submit an investigation report to the Case Manager, normally within 12 weeks of appointment unless there are good reasons to extend that timescale. The report should set out the findings of the investigation and give the Case Manager sufficient information to make the decisions at paragraph 2.14. The Case Investigator should not decide what action should be taken and may not be a member of any disciplinary or appeal panel relating to the case.

The Case Manager's decision as to how to proceed

2.16 Throughout the investigation and/or on review of the investigation report, the Case Manager will decide whether:

2.16.1 restrictions on practice or exclusion from work under section 3 should be considered; and/or

2.16.2 there are concerns about the Practitioner's health that should be dealt with under section 6; and/or

2.16.3 there is a case of misconduct that should be dealt with under section 4; and/or

2.16.4 there are concerns about the Practitioner's performance or capability that should be dealt with under section 5; and/or

2.16.5 there are serious concerns that should be notified to other organisations or referred to the relevant regulatory body under paragraph 1.8; or

2.16.6 that no further action is needed.

2.17 In cases involving both alleged misconduct and capability issues, the Case Manager should consult with PPA and either decide to combine the issues at a capability hearing, or to deal with conduct issues separately.

3 Interim measures, including Restriction of Practice and Exclusion

3.1 When serious concerns are raised about a Practitioner, the Trust must urgently consider whether it is necessary to take temporary, interim measures. The Case Manager will, subject to the overriding duty to protect patients and other staff, seek to ensure that such measures are kept at the least restrictive level of intervention, taking into account the impact on the Practitioner. Measures might include:

3.1.1 any of the measures which should be explored as potential intervention measures - action at paragraphs 2.1 and 2.2, such as additional supervision arrangements, mentoring or buddying, team facilitation or mediation, a temporary behavioural agreement, or agreed undertakings.

3.1.2 Sickness absence or health related support, such as an Occupational Health referral, for the investigation of specific health problems

3.1.3 where there are capability concerns, agreeing an action plan with the Practitioner with the advice of PPA, or an agreed referral of the Practitioner to PPA for assessment; or

3.1.4 temporary restrictions on the Practitioner's practice such as amending or restricting clinical duties, or restriction to administrative, research or audit, teaching and other educational duties. The latter might include some agreed formal retraining or re-skilling.

3.2 As a last resort, it may be necessary, subject to the controls set out below, to exclude the Practitioner from the workplace either immediately (paragraph 3.5) or formally (paragraphs 3.8).

3.3 Exclusion from work must only be used as a temporary, interim measure whilst action to resolve a problem is being considered. It should be used as a precautionary measure and not a conduct sanction.

3.4 The Trust will give authority to exclude to sufficient nominated managers, at an appropriately senior level, to ensure 24-hour availability of such a manager in the event of a critical incident. This authority will include:

3.4.1 The Chief Executive or any Executive Director.

3.4.2 The Chief Medical Officer.

3.4.3 Associate Medical Officers.

3.4.4 Clinical Directors.

3.4.5 Chief People Officer; or

3.4.6 Operations Directors.

Immediate Exclusion

3.5 In most exceptional circumstances when serious concerns have been raised, a manager with the authority to exclude may decide to immediately exclude the Practitioner for a period of no more than two weeks, if this is necessary:

3.5.1 to protect the practitioner, and interests of patients or other staff, for example after a critical incident, or breakdown in relationships between a Practitioner and the rest of the team; or

3.5.2 there is a clear risk that the Practitioner's presence would impede the gathering of evidence, or it is otherwise likely to hinder the investigation.

3.6 The excluding manager must explain to the Practitioner why the exclusion is being made in broad terms or in as much detail where possible and set a date for a further meeting within two weeks. The Case Manager will notify the Practitioner of the exclusion in writing in accordance with paragraph 3.12.

3.7 The two week period may be used to obtain a preliminary report from the Case Investigator, if practicable, or to carry out some initial fact-finding; to contact PPA for advice; to arrange a case conference; and to discuss the case fully, preferably at the case conference, with the Chief Executive, the Chief Medical Officer, the Chief People Officer, PPA and other relevant parties (such as the police where there are serious criminal allegations or the NHS Counter Fraud Service).

Formal exclusion

3.8 The Case Manager may decide to formally exclude a Practitioner where:

3.8.1 There is a need to protect the interests of patients or other staff or the practitioner, pending the outcome of a full investigation of serious concerns; or

3.8.2 The presence of the Practitioner in the workplace is likely to hinder the investigation; and

3.8.3 The alternatives to exclusion at paragraph 3.1 have been considered.

3.9 A formal exclusion may only take place after the Case Manager has:

3.9.1 Considered whether there may be a case to answer including considering any preliminary report or fact-finding that may be available.

3.9.2 Held a case conference and discussed with the Chief Medical Officer and the Chief People Officer whether there is reasonable and proper cause to exclude; and

3.9.3 Notified and consulted with PPA.

3.10 A formal exclusion should be for the minimum necessary period and for no more than four weeks at a time, subject to review and extensions as set out below.

3.11 The Practitioner, in the presence of a witness if possible, should be:

3.11.1 informed of the formal exclusion and the nature of the allegations or areas of concern.

3.11.2 informed of the reasons why formal exclusion is regarded as the only way to deal with the case.

3.11.3 given the opportunity to state their case and propose alternatives to exclusion.

Written notification of exclusion

3.12 As soon as is reasonably practicable, the Practitioner must be informed in writing of the:

3.12.1 exclusion and its effective date and time.

3.12.2 duration of the exclusion (up to 4 weeks formal or 2 for immediate).

3.12.3 content of the allegations.

3.12.4 terms of the exclusion.

3.12.5 fact of an investigation or other action to follow.

3.12.6 Practitioner's or his or her companion's right to make representations about the exclusion to the designated board member at any time.

3.13 The Case Manager should make arrangements, where possible, to ensure that the Practitioner can keep in contact with colleagues on professional developments and take part in CPD and clinical audit activities with the same level of support as other doctors or dentists. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

Terms of Exclusion

3.14 Practitioners should only be barred from the premises upon exclusion if necessary, for example, where there may be a danger of tampering with evidence, or where the Practitioner may be a serious potential danger to patients or other staff.

3.15 The Practitioner must remain available for work during normal contracted hours, subject to at least 24 hours' notice of any return to work. The Practitioner must also seek the Case Manager's consent to take annual leave or study leave.

3.16 Exclusion will usually be on full pay. However, in exceptional circumstances the Case Manager may decide that payment is not justified because the Practitioner is no longer available for work, for example if the Practitioner has left the United Kingdom without agreement. This would be taken to the Pay Advisory Forum (PAF) panel for decision making.

3.17 The Practitioner must inform the Case Manager of any other organisation(s) with whom they undertake voluntary or paid work and seek the Case Manager's consent to continuing such work. In the absence of such consent, the Practitioner may be asked not to undertake any work in the affected area of practice with any other organisation.

3.18 Failure to comply with the above terms of exclusion may result in disciplinary action or referral to the relevant regulatory body.

Review and Cessation or Extension of Exclusions

3.19 The Board should be informed about any exclusion at the earliest opportunity. The Board should also be provided with a written four-weekly or monthly summary of any exclusions, their duration, and the number of times each exclusion has been extended. A copy of this summary must be sent to PPA, and the PPA may also collate into a report for the Department of Health.

3.20 As soon as it is apparent that the reasons for exclusion no longer apply, for example because the concerns are without foundation or the investigation can continue with the Practitioner working normally or with restrictions, the Case Manager must:

3.20.1 lift the exclusion.

3.20.2 inform PPA.

3.20.3 make arrangements for the Practitioner to return to work with any appropriate support, as soon as practicable; and

3.20.4 make clear whether there will be any restrictions or monitoring arrangements to ensure patient safety and, if so, what these will be.

3.21 If requested, the Case Manager must provide a detailed report on any continuing exclusion to the Non-Executive Member.

3.22 Exclusions must be reviewed regularly and, at least, before the end of the four-week duration of any exclusion or any decision to extend it. Careful consideration must be given to whether it is

necessary to continue the exclusion in the interests of patients, other staff, the Practitioner, and/or the investigation and whether there are alternatives.

3.23 Following a review, the Case Manager may decide to extend the exclusion by up to four weeks at a time, until the completion of these procedures, if a return to work is considered inappropriate. If the exclusion is not reviewed before the end of its four-week duration, it will lapse, and the Practitioner will be entitled to return to work.

3.24 After each four-week review, the Case Manager must:

3.24.1 provide a brief report of the review and outcome to the Chief Executive and the Board which demonstrates that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible but does not include details that would prevent members of the Board from sitting on subsequent hearing panels.

3.24.2 send written notification of the extension to the Practitioner and also provide a named contact for a welfare and well-being check in with the Practitioner

3.25 If the Case Manager considers that the exclusion will need to be extended over a prolonged period for reasons outside of his or her control (for example because of a police investigation), advice must be sought from PPA on the effective handling of the case and how to proceed.

3.26 Where an exclusion has continued for three periods:

3.26.1 The Case Manager must provide a report to the Chief Executive: outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed a timetable for completion of the investigation.

3.26.2 The Chief Executive (or a nominated officer) must provide a report to PPA and the Non-Executive Member of what action is proposed to resolve the situation, including dates for hearings, if appropriate, or reasons for the delay and, where retraining or other rehabilitation action is proposed, the reason for continued exclusion.

3.26.3 The case must formally be referred to PPA explaining why continued exclusion is appropriate; what steps are being taken to conclude the exclusion at the earliest opportunity; to enable PPA to review the case and advise the Trust.

3.27 If the exclusion has been extended for more than six months, the Chief Executive must provide a further report to PPA indicating the reason for continuing the exclusion; the anticipated time scale

for completing the process; and the actual and anticipated impacts of the exclusion, for example but not limited to, financial costs, reputation of the Trust (and/or Practitioner), or challenge in facilitating a positive return to work. PPA may provide advice to the Board.

3.28 Exclusions should not normally last for more than 6 months unless they involve criminal investigations. The Trust should actively review such cases with PPA.

3.29 Where a Practitioner returns to work after a lengthy exclusion, the Case Manager should consider how the Practitioner's transition back to the workplace will be supported. The Case Manager may seek advice from PPA and HR and work with the Clinical Director. A return to work meeting should be arranged with the Practitioner to discuss this transition and a return to work plan, which may include:

3.29.1 The level of supervision required (direct or indirect)

3.29.2 Targeted training

3.29.3 Progress reviews and agreed "milestones"

3.29.4 Anticipated timings for recommencing independent practice

3.29.5 Arrangements for phased return

3.29.6 Occupational Health and Well-being advice

3.29.7 Altered duties

3.29.8 A Mentor to provide additional support to the Practitioner

4 Allegations of Misconduct

4.1 Where a Case Manager, having received the Case Investigator's report decides that there is a case to consider allegations of misconduct, these should be dealt with under the Trust's Improving and Managing Conduct Policy. In particular:

4.1.1 Any further investigation should normally be carried out by the Case Investigator already appointed to supplement the investigation under section 2. Alternatively, the investigation under section 2 may already be sufficient to proceed straight to a hearing; and

4.1.2 A hearing and any appeal will follow the Improving and Managing Conduct Procedure.

4.1.3 where misconduct is alleged to relate to fraud, bribery and/or corruption a referral will be made to the Trusts Local Counter Fraud Specialist in accordance with the Trust's Local Fraud, Bribery and Corruption Policy

4.2 In respect of the application of these procedures once the Case Manager has decided there is a case to consider allegations of misconduct:

4.2.1 The principles of section 1 including the broader Right to be Accompanied; section 3 in respect of any exclusion; this section 4; and section 6 in respect of health concerns, will continue to apply in addition to the Trust's Improving and Managing Conduct Procedure.

4.2.2 Section 5 in respect of capability procedures, hearings and appeals will not apply.

4.3 Examples of misconduct applicable to all other members of staff at the Trust, including those set out in the Trust's Improving and Managing Conduct Procedure are equally applicable to Practitioners. In addition, particular examples of misconduct by a Practitioner may include failures to:

4.3.1 Fulfil contractual obligations, such as regular non-attendance at ward rounds or clinics, or not taking part in clinical governance activities.

4.3.2 Give proper support to other staff, including doctors or dentists in training.

4.3.3 Comply with the requirements of the GMC's Good Medical Practice or the GDC's Standards for Dental Professionals or other relevant code of professional conduct.

Incorrect classification of misconduct

4.4 If the Practitioner considers that a case has been wrongly classified as misconduct, he or she may raise a formal request for resolution or make representations to the Non-Executive Member.

However, the Trust may decide not to instigate separate formal resolution procedures, but to deal with any such complaint within the capability or conduct process as appropriate.

Allegations of Professional Misconduct

4.5 Concerns of professional misconduct should be interpreted to mean allegations which are likely to require an element of clinical judgment which only doctors or dentists, as opposed to other Trust employees, are professionally qualified to make, investigate, or adjudicate upon.

4.6 Where the matter involves allegations of professional misconduct, the:

4.6.1 Case Manager may seek advice from PPA.

4.6.2 Case Investigator may need to obtain appropriate independent professional advice during the investigation.

4.6.3 Panel at any hearing under the Trust's Improving and Managing Conduct Procedure may need to include a member who is medically or dentally (as appropriate) qualified and who is not currently employed by the Trust.

Allegations of Criminal Acts

4.7 If a Practitioner is charged with or convicted of a criminal offence, the Trust must consider whether this might affect his or her suitability for employment and whether the Practitioner poses a risk to patients or colleagues. If so, the Trust should:

4.7.1 instigate its own investigation under these procedures.

4.7.2 consider whether it is necessary to exclude or restrict the practice of the Practitioner.

4.7.3 explain to the Practitioner the reasons for taking such action.

4.8 Where the Trust's investigation establishes a suspected criminal action in the UK or abroad, this may need to be reported to the police. In cases of suspected fraud, the Counter Fraud, Bribery and or Corruption Service should be contacted.

4.9 Where a police or NHS Counter Fraud investigation is underway, the Trust should consult the police or Local Counter Fraud Specialist to establish whether a Trust investigation would impede the police or NHS fraud investigation. Where possible, however, the Trust will want to avoid unwarranted delay.

4.10 If the police and/or Local Counter Fraud Specialist decide not to pursue criminal allegations against the Practitioner, or if the Practitioner is acquitted of criminal charges, which might affect

his or her suitability for employment, the Trust may nonetheless decide to proceed with its own investigation into the same or related matters if it considers that there is sufficient evidence to do so, bearing in mind the high burden of proof in criminal proceedings and the Trust's duty to ensure patient safety.

5 Capability Procedure

5.1 Where a Case Manager, having received the Case Investigator's report, decides that there are concerns about the Practitioner's performance or capability, the Case Manager may decide to follow the capability procedures under this section.

5.2 Concerns that an individual may have failed to deliver an adequate standard of care or management, through lack of knowledge, ability, or consistently poor performance, will usually be treated as capability issues. For example, this will include concerns about:

5.2.1 out of date clinical practice.

5.2.2 inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk.

5.2.3 incompetent clinical practice.

5.2.4 inability to communicate effectively.

5.2.5 inappropriate delegation of clinical responsibility.

5.2.6 inadequate supervision of delegated clinical tasks; and/or

5.2.7 ineffective clinical team working skills.

Initial Considerations

5.3 Before taking further action under these capability procedures, the Case Manager:

5.3.1 must provide any Investigation Report to the Practitioner.

5.3.2 must give the Practitioner 10 working days (or more in exceptional circumstances such as complex cases or due to annual leave) to comment in writing on any Investigation Report.

5.3.3 should consider whether the concerns can be locally resolved by counselling, retraining or performance review; and

5.3.4 should consider whether there are ill-health issues that should be dealt with through the Trust's normal ill-health procedures.

5.4 If local resolution of the concerns is not practicable, the Case Manager must decide, having taken advice from PPA, whether:

5.4.1 an action plan can be prepared to address the concerns and, if so, the contents of that plan; and/or

5.4.2 a PPA assessment should be carried out; or

5.4.3 the Practitioner's performance is so fundamentally flawed that an action plan will not have a realistic chance of success, in which case the Case Manager may decide to convene a capability hearing.

5.5 The Case Manager will inform the Practitioner of the decision as to how to proceed, normally within 10 working days of receiving the Practitioner's comments.

5.6 If the Case Manager decides to prepare an action plan and/or that a PPA assessment should be carried out, the Case Manager will seek the Practitioner's agreement to this. If this is agreed, the Trust will facilitate the action plan and/or assessment. If this is not agreed, see 5.8.

5.7 Where an action plan is to be prepared, the Trust will normally seek to use structured further training as recommended by PPA's "The Back on Track Framework for Further Training" (2010). The Case Manager may appoint a programme director and/or clinical supervisor to assist with preparing this. Training will normally be carried out at the Practitioner's workplace but may involve an external placement where appropriate. Where there is a cost attached to the training, the doctor may be asked to make a reasonable contribution towards that cost, in line with the Back on Track guidance.

5.8 If the action plan or PPA assessment, or its continuation, is not agreed by the Practitioner at any stage, after reasonable attempts to do so by the Trust, or if the Practitioner fails to engage with the action plan or assessment, the Trust will normally convene a capability hearing.

Convening a Capability Hearing

5.9 The Case Manager must give the Practitioner at least two weeks' written notice of a capability hearing. This should include:

5.9.1 The allegations to be considered.

5.9.2 The Practitioner's right to be accompanied.

5.9.3 Copies of any documentation and/or evidence, including any witness statements, that will be made available to the capability panel; and

5.9.4 The members of the panel.

5.10 The Practitioner must provide any documentation and/or evidence, including any witness statements on which he or she wishes to rely, at least one week before the hearing.

Witnesses

5.11 Either the Case Manager or the Practitioner may request that relevant witnesses attend the hearing. Each will normally be expected to arrange the attendance of their own witnesses.

The Hearing Panel

5.12 The panel for the hearing should:

5.12.1 Comprise 2 appropriately senior people.

5.12.2 Include a Chair who will normally be an Executive Director; and

5.12.3 Not include, as far as is reasonably possible, anyone who has been previously involved in the investigation.

5.13 Arrangements should be made for the hearing panel to be advised by:

5.13.1 A senior member of the People team, and

5.13.2 If none of the panel members can advise on the appropriate level of competence, an independent clinician (who may be from another Trust) at the same grade and in the same or similar clinical specialty as the Practitioner.

5.14 The Practitioner may object to the choice of any panel member within 5 working days of notification. The choice of panel is for the Trust, but the Trust should give reasonable consideration to any such objection.

Conduct of a capability hearing

5.15 The Chair will be responsible for the conduct of the hearing, which should not be conducted overly formally, but should give the Practitioner every reasonable opportunity to present his or her case.

5.16 The panel, its advisers, the Case Manager, the Practitioner and any companion or representative of the Practitioner will be present throughout the hearing. Witnesses should only attend only to give their evidence and answer questions by all parties and the panel.

Decisions

5.17 The decision of the panel will normally be communicated to the parties within 5 working days of the hearing and may include a range of outcomes, including but not limited to:

5.17.1 That no action is required.

5.17.2 Comments and recommendations on issues other than the competence of the Practitioner, but relevant to the case, such as suggested improvements to systems and procedures.

5.17.3 A verbal requirement that the Practitioner should demonstrate an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved (to stay on the Practitioner's record for six months).

5.17.4 A written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved (to stay on the Practitioner's record for one year).

5.17.5 A final written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved (to stay on the Practitioner's record for one year, or more if there is good reason for this).

5.17.6 That the Practitioner's contract of employment should be terminated.

5.18 The decision of the panel must be confirmed in writing to the Practitioner, together with the reasons for the decision, the Practitioner's right of appeal and notice of any intention to make a referral to any regulatory or external body.

Appeals against Capability Decisions

5.19 If the Practitioner wishes to appeal, he or she should submit a written statement of appeal to the Trust's Chief People Officer within 25 working days of the date of the written confirmation of the original decision.

5.20 The Trust should arrange an appeal hearing to take place as soon as reasonably possible.

5.21 All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence. The appeal panel may also call additional witnesses or evidence of its own volition.

The Appeal Panel

5.22 The appeal panel should:

5.22.1 Comprise two appropriately senior people who have not had any previous direct involvement in the subject of the appeal, including a Chair who is a member of the Trust board.

5.23 Arrangements should be made for the hearing panel to be advised by:

5.23.1 A senior member of the People team, and

5.23.2 If none of the panel members can advise on the appropriate level of competence, an independent clinician (who may be from another Trust) at the same grade and in the same or similar clinical specialty as the Practitioner.

Process of the Appeal Hearing

5.24 Both parties should have the opportunity to present evidence and make representations to the appeal panel and should answer questions from the other party and the panel. When all the evidence has been presented, both parties shall briefly sum up (which may include any evidence in mitigation for the Practitioner).

5.25 The appeal panel can also hear new evidence submitted by the Practitioner and consider whether it might have significantly altered the decision of the original panel. However, the appeal panel should not rehear the entire case.

Decision of the appeal panel

5.26 The appeal panel should adjourn to make its decision in private. The written decision should be sent to the Practitioner and the Case Manager normally within 5 working days of the hearing. The appeal panel may:

5.26.1 Confirm or vary the decision made by the original panel; and/or

5.26.2 Reinstate a dismissed Practitioner, in which case the Practitioner must receive full pay since their dismissal; or

5.26.3 Order that the case is reheard, where proper procedures have not been followed, in which case a dismissed Practitioner should be reinstated subject to any conditions or restrictions in place at the time of the original hearing.

6 Handling Concerns about a Practitioner's Health

6.1 Matters relating to a Practitioner's ill-health and sickness absence should generally be dealt with in accordance with the Trust's Absence Management Policy and Procedure, subject to the additional requirements set out below. It may not be necessary in such cases to follow all the other policy principles in this document.

6.2 PPA should be asked to advise on any situation where concerns are raised about a doctor or dentist's health.

6.3 If a Practitioner's ill health makes them a danger to patients and they do not recognise that or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and the professional regulatory body must be informed, whether or not the Practitioner has retired on the grounds of ill health.

7 Review

7.1 This policy may be reviewed at any time at the request of either staff side or management but will automatically be reviewed after 2 years or as required following any amendments to national guidance.

Appendix 1

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity, and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation, and other conduct prohibited by the Equality Act of 2010.
- **advance equality of opportunity** between people who share a protected characteristic and people who do not.
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	People Services	
Title of Change:	Policy for Managing Performance of Medical & Dental Staff	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Incorporate NHSI guidance, just culture principles, person centred approach	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	

Pregnancy and maternity			X	
Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers, or other voluntary sector groups?)	Yes	Internal stakeholders – DDNC
Have you taken into consideration any regulations, professional standards?	Yes	ACAS Code, NHSI recommendations as per Dido Harding letter, NHS People Plan, Just Culture Guide

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	☐	■	☐
What action needs to be taken to reduce or eliminate the negative impact?	Fair and consistent application of policy		
Who will be responsible for monitoring and regular review of the document / policy?			

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:		*Date:*	*16 March 2022*

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	Disability	A person has a disability if they have a physical or mental impairment which has a substantial and long-term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	• Further guidance can be sought from: • Solent Disability Resource Group
2.	Sex	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	• Further guidance can be sought from: • Solent HR Team
3	Race	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	• Further guidance can be sought from: • BAME Resource Group
4	Age	Refers to a person belonging to a particular age range of ages (e.g., 18-30-year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	• Further guidance can be sought from: • Solent HR Team
5	Gender Reassignment	" The expression of gender characteristics that are not stereotypically associated with one's sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	• Further guidance can be sought from: • Solent LGBT+ Resource Group
6	Sexual Orientation	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	• Further guidance can be sought from: • Solent LGBT+ Resource Group
7	Religion and/or belief	• Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs, including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	• Further guidance can be sought from: • Solent Multi-Faith Resource Group • Solent Chaplain
8	• Marriage	• Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	• Further guidance can be sought from: • Solent HR Team
9	• Pregnancy and Maternity	• Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	• Further guidance can be sought from: • Solent HR team

Appendix 2

A just culture guide

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

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

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

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

Please note:

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

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

→ Y

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

END HERE

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

→ Yes

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

END HER

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

→ Yes

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

END HERE

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

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

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

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

→ If No to any

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

END HERE

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

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

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

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

→ If Yes to any

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

END HERE

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

5a. Were there any significant mitigating circumstances?

→ Yes

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

END HER

if No

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

END HER

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

Supported by:

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