

## **Maintaining High Professional Standards in the NHS (MD 29)**

If you require a copy of this policy in an alternative format (for example large print, easy read) or would like any assistance in relation to the content of this policy, please contact the Diversity & Inclusion Officer on 01803 656705.

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LNC		March 2006	
Medical Workforce		March 2021	
<b>Links or overlaps with other policies:</b>			
<i>Need to list all policies that are referred to, or have links to this policy. List them in numeric order.</i>			

### Amendment History

Issue	Date	Reason for Change	Authorised
1	March 2006	Replaced Professional Conduct/Capability Procedure Initial Handling of Concerns about Doctors and Dentists in the NHS	LNC
1.2	March 2021	New Policy Template change NCAS to NHS Resolution – quick review	Medical Workforce

**Rapid (E)quality Impact Assessment (EqIA)** (for use when writing policies)

<b>Policy Title</b> (and number)	<b>Maintaining High Professional Standards in the NHS</b>	<b>Version and Date</b>	V1.2 Feb 2021
<b>Policy Author</b>			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
<b>Who may be affected by this document?</b>			
Patients/ Service Users <input type="checkbox"/> Staff <input checked="" type="checkbox"/> Other, please state... <input type="checkbox"/>			
<b>Could the policy treat people from protected groups less favorably than the general population?</b> <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Sexual Orientation			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Religion/Belief (non)			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Marriage/ Civil Partnership			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population?</b> (substance misuse; teenage mums; carers <sup>1</sup> ; travellers <sup>2</sup> ; homeless <sup>3</sup> ; convictions; social isolation <sup>4</sup> ; refugees)			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>Please provide details for each protected group where you have indicated 'Yes'.</b>			
<b>VISION AND VALUES:</b> Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language <sup>5</sup> used throughout?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Are the services outlined in the policy fully accessible <sup>6</sup> ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Does the policy encourage individualised and person-centered care?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy <sup>7</sup> ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input checked="" type="checkbox"/>
<b>EXTERNAL FACTORS</b>			
<b>Is the policy a result of national legislation which cannot be modified in any way?</b>			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>What is the reason for writing this policy?</b> (Is it a result in a change of legislation/ national research?)			
<b>Trust's procedure for handling concerns about doctors' and dentists' conduct and capability.</b>			
<b>Who was consulted when drafting this policy?</b>			
Patients/ Service Users <input type="checkbox"/>	Trade Unions <input checked="" type="checkbox"/>	Protected Groups (including Trust Equality Groups) <input type="checkbox"/>	
Staff <input type="checkbox"/>	General Public <input type="checkbox"/>	Other, please state... <input type="checkbox"/>	
<b>What were the recommendations/suggestions?</b>			
<b>Does this document require a service redesign or substantial amendments to an existing process?</b> <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>ACTION PLAN:</b> Please list all actions identified to address any impacts			
<b>Action</b>	<b>Person responsible</b>	<b>Completion date</b>	

**Please contact the Equalities team for guidance:** For Torbay and South Devon NHS Trusts, please call 01803 656676 or email [pdf.sdht@nhs.net](mailto:pdf.sdht@nhs.net) **This form should be published with the policy and a signed copy sent to your relevant organisation.**

<sup>1</sup> Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

<sup>2</sup> Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

<sup>3</sup> Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

<sup>4</sup> Consider how someone will be aware of (or access) a service if socially or geographically isolated

<sup>5</sup> Language must be relevant and appropriate, for example referring to partners, not husbands or wives

<sup>6</sup> Consider both physical access to services and how information/ communication is available in an accessible format

<sup>7</sup> Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

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## **1. Policy Statement**

- 1.1 This is an agreement between Torbay & South Devon NHS Foundation Trust and the Joint Local Negotiating Committee outlining the Trust's procedure for handling concerns about doctors' and dentists' conduct and capability. It implements the framework set out in 'Maintaining High Professional Standards in the Modern NHS', issued under the direction of the Secretary of State for Health on 11 February 2005.

This procedure may be amended to reflect any future national advice or guidance but only by agreement with the JLNC. Where there is any conflict or lack of clarity the existing national agreed guidance will take precedence.

## **2 Purpose**

- 2.1 The Trust, recognising the honesty and integrity of its staff, believes that personal and professional conduct should be largely self-regulated. The Trust accepts that breaches of the rules of conduct and standards of performance will occur from time to time. The Trust expects to deal with these breaches firmly but with sensitivity. Breaches should, wherever appropriate, be dealt with informally 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.
- 2.2 Where formal disciplinary action is used, it should emphasise and encourage improved standards of performance/conduct. It is not a means of punishment.
- 2.3 Practitioners who are subject to the procedures in this document will be provided with a summary of rights (see Appendix A). Practitioners have the right to be represented and/or accompanied by an accredited representative of a trade union or a workplace colleague.
- 2.4 It is a principle of these procedures that where appropriate, issues are dealt with by the immediate clinical line manager of the practitioner.
- 2.5 It is recognised that it may be appropriate on occasions after consideration by the Medical Director, Chair of CMSC and/or Chair of JLNC, Director of Workforce & OD or Chief Executive (hereafter referred to as MD, CCMSC, CLNC, DWOD and CEO) to inform the General Medical Council (GMC), NHS Resolution and other outside agencies about issues dealt with under these procedures.
- 2.6 This policy applies to all medical and dental staff employed by the Trust. Medical and dental staff who hold honorary contracts with the Trust and Undergraduates will also be subject to these procedures. Where disciplinary action is contemplated, and the issues relate to a doctor in training, then the Postgraduate Medical Dean's office should be informed.
- 2.7 Where within this policy an issue is referred to the MD, CCMSC, CLNC and DWOD or nominated deputies, it is understood that the MD or nominated deputy has the responsibility for making the final decision after seeking advice.

### 3 Scope

- 3.1 This policy applies to all staff employed by Torbay & South Devon NHS Foundation Trust, together with those on a joint contract with the organisation and another employer.

### 4 Equality and Diversity Statement

- 4.1 The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): sexual orientation; gender; age; gender re-assignment; pregnancy and maternity; disability; religion or belief; race; marriage and civil partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.
- 4.2 The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis.

### 5 Explanatory Note

This policy is taken from the national framework developed by the Department of Health, the NHS Confederation, the British Medical Association and the British Dental Association and applies to the NHS in England. It covers:

- ◆ Action to be taken when a concern about a doctor or dentist first arises;
- ◆ Procedures for considering whether there need to be restrictions placed on a doctor or dentists practice or suspension is considered necessary.
- ◆ Guidance on conduct hearings and disciplinary procedures.
- ◆ Procedures for dealing with issues of capability.
- ◆ Arrangements for handling concerns about a practitioners health.

### 6 DEFINITIONS OF CONDUCT/COMPETENCE

The following definitions and examples constitute guidance in defining the category of alleged misconduct. It is for the Medical Director to decide which category a case falls:

**Personal Conduct:** performance or behaviour of a practitioner due to factors other than those associated with the exercise of medical or dental skills. Personal misconduct would normally relate to a deliberate act or omission where a motive is involved, e.g. personal gain or malicious damage.

In cases involving personal misconduct the Trust's general Disciplinary Policy (No 31) will apply.

**Professional Conduct:** performance or behaviour of a practitioner arising from the exercise of medical or dental skills.

**Professional Competence:** adequacy of performance of a practitioner arising from the exercise of medical or dental skills and professional judgment.

## 7 Initial Procedure

- 7.1 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 without resort to the MD. In such circumstances, it may or may not be appropriate for the MD to be informed of the outcome.
- 7.2 If a matter comes to the attention of the MD, then he/she has the discretion to resolve the matter directly or investigate the issue in-house. That may include setting up a small panel of up to three appropriate medical practitioners/medical managers. Where the matter involves specialist expertise not available within the Trust the MD may appoint (and the practitioner may request) an additional external practitioner with the expertise who is acceptable to both the MD and practitioner under investigation. If appropriate this person's contribution may be by telephone, email or letter. The above approach can be utilised for the full range of issues including those of potential harassment and bullying.
- 7.3 If at a later stage it is considered by the MD or deputy that there is a case to answer of sufficient gravity, these issues will then pass over to the appropriate Trust policy following discussions with the CCMSC/CLNC and DWOD.
- 7.4 If the MD chooses to adopt the in-house procedure the practitioner in question will be informed of this fact in writing together with the details of the issue under investigation and a summary of their rights. Following the in-house investigation, the practitioner will be provided with a summary of the findings and recommendations of the investigatory panel and will be invited to a meeting if necessary. The practitioner will be advised in writing that:
- i. There is no case to answer and no further action is required, or
  - ii. That the matter will be investigated in accordance with the appropriate formal procedure,  
or
  - iii. The details of the MD's proposals for resolving the matter as an alternative to following the appropriate formal procedure. This may include remedial supportive action, further training or modification of responsibility, job plan review, referral to the occupational health department, or issuing formal verbal or written warning by the MD or CEO. The appropriate formal procedure will be followed if the practitioner does not agree to the MD's proposals in this regard.

Following 7.4 above, the matter will ideally be considered within two weeks of the MD advising the practitioner in writing.

## **8 Action When A Concern Arises**

- 8.1. The management of performance is a continuous process which is intended to identify 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 disciplinary procedures.
- 8.2. Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:
- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff;
  - Review of performance against job plans, annual appraisal, revalidation
  - Monitoring of data on performance and quality of care;
  - Clinical governance, clinical audit and other quality improvement activities;
  - Complaints about care by patients or relatives of patients;
  - Information from the regulatory bodies;
  - Litigation following allegations of negligence;
  - Information from the police or coroner;
  - Court judgments.
- 8.3. Unfounded and malicious allegations can cause lasting damage to a doctor's reputation and career prospects. Therefore, all allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to verify the facts so that the allegations can be shown to be true or false.
- 8.4. Concerns about the capability of doctors and dentists in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.
- 8.5. All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. The Chairman of the Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director will need to work with the Director of Workforce & OD to decide the appropriate course of action in each case. The Medical Director will act as the case manager or may delegate this role to a senior manager or clinician to oversee the case on his or her behalf. The Medical Director is responsible for appointing a case investigator.

## **9 Exclusion**

- 9.1 When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace.
- 9.2 At any point in the process where the case manager has reached the clear judgment that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the GMC/GDC, whether or not the case has been referred to the NHS Resolution. Consideration should also be given to whether the issue of an alert letter should be requested.



## 10 Identifying If There is A Problem

- 10.1 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 disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with the Director of Workforce & OD and the Medical Director and NHS Resolution.
- 10.2 The case managers should explore the potential problem with the NCAS to consider different ways of tackling it themselves, possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than the NHS Resolution.
- 10.3. The case manager should not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of adverse events 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 National Patient Safety Agency (NPSA) facilitates the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses and the case manager should consider contacting the NPSA for advice about systems or organisational failures.
- 10.4 Having discussed the case with the NHS Resolution the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen NHS Resolution should still be involved until the problem is resolved.
- 10.5 Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Director of Workforce & OD, appoint an appropriately experienced or trained person as case investigator. The seniority of the case investigator will differ depending on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained, to enable them to carry out this role when required.
- 10.6 The case investigator:
- Is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings;
  - Must formally involve a senior member of the medical or dental staff nominated by the medical staff committee chair [or equivalent] where a question of clinical judgement is raised during the investigation process. (Where no other suitable senior doctor or dentist is employed by the Trust a senior doctor or dentist from another NHS body should be approached);
  - Must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but any disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered. The investigator will approach the practitioner concerned to seek views on information that should be collected;

- Must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene any disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report;
- Must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Director of Workforce & OD with the Medical Director;
- Must assist the designated Board member in reviewing the progress of the case.

## **The Investigation**

- 10.7. The case investigator does not make the decision on what action should be taken nor whether the employee should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.
- 10.8 The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided, that an investigation is to be undertaken, 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.
- 10.9 At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body; an official or representative of the British Medical Association [,any other recognised trade union], British Dental Association or a defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity.
- 10.10 The case investigator has discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended simply to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter.
- 10.11 If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should arrange for a practitioner in the same specialty and same grade from another NHS body to assist.
- 10.12. The case investigator should complete the investigation within 4 weeks of appointment and submit their report to the case manager within a further 5 days. The report of the investigation should give the case manager sufficient information to make a decision whether:
- There is a case of misconduct that should be put to a conduct panel;
  - There are concerns about the practitioner's health that should be considered by the NHS body's occupational health service;
  - There are concerns about the practitioner's performance that should be further explored by NHS Resolution
  - Restrictions on practice or exclusion from work should be considered;
  - There are serious concerns that should be referred to the GMC or GDC;

- There are intractable problems and the matter should be put before a capability panel;
- No further action is needed.

## **11 Involvement of NHS Resolution following local investigation**

11.1 Medical under-performance can be due to health problems, difficulties in the work environment, behaviour or a lack of clinical capability. These may occur in isolation or in a combination. NHS Resolution processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. NHS Resolution's methods of working therefore assume commitment by all parties to take part constructively in a referral. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.

11.2 The focus of the NHS Resolutions work is therefore likely to involve performance difficulties which are serious and/or repetitive. That means:

- Performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk;
- Alternatively or additionally, problems that are ongoing or (depending on severity) have been encountered on at least two occasions.

In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process. NHS Resolution may advise on this.

11.3. Where the Trust is considering excluding a doctor or dentist (whether or not his or her performance is under discussion with NHS Resolution), the Trust will inform NHS Resolution of this at an early stage, so that alternatives to exclusion are considered. It is particularly desirable to find an alternative when NHS Resolution is likely to be involved, because it is much more difficult to assess a doctor who is excluded from practice than one who is working.

11.4. A practitioner undergoing assessment by NHS Resolution must cooperate with any request to give an undertaking not to practice in the NHS or private sector other than their main place of NHS employment until the NHS Resolution assessment is complete.

11.5 Failure to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the employer on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the parties and may necessitate disciplinary action and consideration of referral to the GMC or GDC.

## **12 Confidentiality**

12.1. The Trust and its employees will maintain confidentiality at all times. No press notice will be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The employer will only confirm publicly that an investigation or disciplinary hearing is underway.

- 12.2. Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose, nor disproportionate to the seriousness of the matter under investigation. The trust will operate consistently with the guiding principles of the Data Protection Act.

## **13 RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK**

### **Introduction**

- 13.1 In this part of the procedure, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practise hearing.
- 13.2 The Trust will ensure that:
- Exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
  - Where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
  - All extensions of exclusion are reviewed and a brief report provided to the Chief Executive and the Board;
  - A detailed report is provided when requested to a single non-executive member of the Board (the "Designated Board Member") who will be responsible for monitoring the situation until the exclusion has been lifted.

### **Managing the risk to patients**

- 13.3 When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Exclusion will be considered as a last resort if alternative courses of action are not feasible.
- 13.4 Exclusion of clinical staff from the workplace is a temporary expedient. Exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work ("suspension") will be reserved for only the most exceptional circumstances.
- 13.5 The purpose of exclusion is:
- To protect the interests of patients or other staff; and/or
  - To assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.
- It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness on the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.
- 13.6 Alternative ways to manage risks, avoiding exclusion, include:
- Medical or clinical director supervision of normal contractual clinical duties;
  - Restricting the practitioner to certain forms of clinical duties;

- Restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling;
- Sick leave for the investigation of specific health problems.

13.7 In cases relating to the capability of a practitioner, consideration will be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach will be sought from NHS Resolution. If the nature of the problem and a workable remedy cannot be determined in this way, the case manager will seek to agree with the practitioner to refer the case to NHS Resolution, which can assess the problem in more depth and give advice on any action necessary. The case manager will seek telephone advice from NHS Resolution when considering restriction of practice or exclusion.

### **The Exclusion Process**

13.8 The Trust will not exclude a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Key officers and the Trust Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

### **Roles of officers**

13.9 The Trust Chief Executive has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The case will be discussed fully with the Chief Executive, the Medical Director, the Director of Workforce & OD, NHS Resolution and other interested parties (such as the police where there are serious criminal allegations or the Counter Fraud & Security Management Service) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

13.10 The authority to exclude a member of staff is vested in:

- ◆ The Chief Executive or his deputy
- ◆ Medical Director or his deputy
- ◆ Director of Workforce & OD

The Chair of the CMSC and Associate & System Medical Directors will be consulted as appropriate.

13.11 The Medical Director will act as the case manager in the case of consultant staff, or delegate this role to a senior manager to oversee the case, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member. The investigating officer will provide factual information to assist the case manager in reviewing the need for exclusion and making progress reports to the Chief Executive and designated Board member.

### **Role of designated Board member**

13.12 At any stage in the process, the practitioner may make representations to the designated Board member in regard to exclusion, or investigation of a case. This is in addition to any right the practitioner may have to appeal against the suspension under the Trust's appeal procedure.

The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights.

### **Immediate exclusion**

13.13 In exceptional circumstances, an immediate time-limited exclusion may be necessary for the purposes identified above following:

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

Such an exclusion will allow a more measured consideration to be undertaken and NHS Resolution should be contacted before the immediate exclusion takes place. This period should be used to carry out a preliminary situation analysis, to seek further advice from NHS Resolution and to convene a case conference. The manager making the exclusion must explain why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date up to a maximum of two weeks away at which the practitioner should return to the workplace for a further meeting. The case manager must advise the practitioner of their rights, including rights of representation.

### **Formal exclusion**

13.14 A formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. NHS Resolution must be consulted where formal exclusion is being considered. If a case investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the case manager to decide on the next steps as appropriate.

13.15 The report should provide sufficient information for a decision to be made as to whether:

- The allegation appears unfounded; or
- There is a potential misconduct issue; or
- There is a concern about the practitioner's capability; or
- The complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be inquired into.

13.16 Formal exclusion of one or more clinicians must only be used where:

(a) There is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:

- Allegations of misconduct,
- concerns about serious dysfunctions in the operation of a clinical service,
- concerns about lack of capability or poor performance of sufficient;

or

(b) The presence of the practitioner in the workplace is likely to hinder the investigation.

- 13.17 Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.
- 13.18 When the practitioner is informed of the exclusion, there should be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to NHS Resolution with voluntary restriction).
- 13.19 The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises and the need to remain available for work) and that a full investigation or what other action will follow. The practitioner and their companion should be advised that they may make representations about the exclusion to the designated board member at any time after receipt of the letter confirming the exclusion.
- 13.20 In cases when disciplinary procedures are being followed, exclusion may be extended for four-week renewable periods until the completion of disciplinary procedures if a return to work is considered inappropriate. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.
- 13.21 If the case manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred to NHS Resolution for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period the principle of four-week "renewability" must be adhered to.
- 13.22 If at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

### **Exclusion from premises**

- 13.23 Practitioners will not be automatically barred from the premises upon exclusion from work. The case manager must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, 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. In other circumstances, however, there may be no reason to exclude the practitioner from the premises.

### **Keeping in contact and availability for work**

- 13.24 The practitioner should be allowed to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

- 13.25 Exclusion under this procedure will be on full pay, therefore the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continuing to undertake such work or to take annual leave or study leave. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the case manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).
- 13.26 The case manager should make arrangements to ensure that the practitioner can keep in contact with colleagues on professional developments, and take part in Continuing Professional development (CPD) and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

### **Informing other organisations**

- 13.27 In cases where there is concern that the practitioner may be a danger to patients, the Trust may consider that it has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.
- 13.28. Where the case manager believes that the practitioner is practising in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, he or she should contact the professional regulatory body and the Director of Public Health or Medical Director of Clinical Commissioning Group to consider the issue of an alert letter.

### **Informal exclusion**

- 13.29 No practitioner will be excluded from work other than through this new procedure. The Trust will not use "gardening leave" or other informal arrangements as a means of resolving a problem covered by this procedure.

### **Keeping Exclusions Under Review:**

#### **Informing the Board**

- 13.30. The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. Therefore:
- A summary of the progress of each case at the end of each period of exclusion will be provided to the Board, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible;

#### **Regular review**

- 13.31 The case manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive and the Board. This report is advisory and it would be for the case manager to decide on the next steps as appropriate. The exclusion



should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed. It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

13.32 The NHS body must take review action before the end of each 4-week period. After three exclusions, NHS Resolution must be called in. The information below outlines the activities that must be undertaken at different stages of exclusion.

13.33 The Trust will use the same timeframes to review any restrictions on practice that have been placed on a practitioner, although the requirements for reporting to the Board do not apply in these circumstances.

### **First and second reviews (and reviews after the third review)**

13.34 Before the end of each exclusion (of up to 4 weeks) the case manager must review the position.

- The case manager decides on next steps as appropriate, taking into account the views of the practitioner. Further renewal may be for up to 4 weeks;
- The case manager submits an advisory report of outcome to Chief Executive and the Trust Board;
- Each renewal is a formal matter and must be documented as such;
- The practitioner must be sent written notification on each occasion.

### **Third review**

13.35 If the practitioner has been excluded for three periods:

- A report must be made to the Chief Executive outlining the reasons for the continued exclusion, 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;
- The Chief Executive must report to the CCG and the designated Board member;
- The case must formally be referred to NHS Resolution explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion, at the earliest opportunity;
- NHS Resolution will review the case with the CCG and advise the Trust on the handling of the case until it is concluded.

### **6 months review**

13.36 If the exclusion has been extended over six months:

- A further position report must be made by the Chief Executive to the CCG indicating the reason for continuing the exclusion, the anticipated time scale for completing the process and the actual and anticipated costs of exclusion;

- The CCG will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can offer to the Board.

13.37 There will be a normal maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and NHS Resolution will actively review such cases at least every six months.

### **Appeal**

13.38 At any stage when a practitioner is suspended or has restrictions placed on their practice, they may appeal to a panel convened by the Trust. Once an appeal has been heard, the practitioner will not be allowed to appeal again for a period of 3 months. The panel will consist of a Trust Executive Director appointed by the medical director (to chair the panel), a consultant appointed by the Medical Staff Committee and a third member from the same specialty and grade as the suspended practitioner from outside the Trust. The panel will recommend to the Chief Executive whether the exclusion or restriction should continue or be lifted.

### **The role of the CCG in monitoring exclusions**

13.39 When an exclusion decision has been extended twice, the Chief Executive of the Trust (or a nominated officer) must inform the CCG of what action is proposed to resolve the situation. This will include dates for hearings or give reasons for the delay. Where retraining or other rehabilitation action is proposed, the reason for continued exclusion must be given.

### **The role of the Board and designated member**

13.40 Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review.

13.41 The Board is responsible for designating one of its non-executive members as a “designated Board member” under these procedures. The designated Board member is the person who oversees the case manager and investigating manager during the investigation process and maintains momentum of the process.

13.42 This member's responsibilities include:

- Receiving reports and reviewing the continued exclusion from work;
- Considering representations from the practitioner about his or her exclusion;
- Considering any representations about the investigation;

### **Return To Work**

13.43 If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged or what the duties and restrictions are to be and any monitoring arrangements to ensure patient safety.

## 14 CONDUCT AND DISCIPLINARY MATTERS

- 14.1 Misconduct matters for doctors and dentists, as for all other staff groups, are dealt with under the Trust's general Disciplinary Procedure (Policy No 31) . However, where any concerns about the performance or conduct of a medical practitioner are raised, the Trust will contact NHS Resolution for advice before proceeding.
- 14.2. Where the alleged misconduct being investigated under the [name of the Trust's misconduct procedure] relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional conduct proceeds to a hearing under the employer's conduct procedures the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.  
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- 14.3 The Trust will work with the relevant University to ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts.
- 14.4 The Trust's Disciplinary Procedure sets out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct", these will generally fall into four distinct categories:
- ◆ A refusal to comply with reasonable requirements of the Trust.
  - ◆ An infringement of the Trust's disciplinary rules including conduct that contravenes the standard of professional behaviour required by doctors and dentists by their regulatory body.
  - ◆ The commission of criminal offences outside the place of work, which may, in particular circumstances, amount to misconduct.
  - ◆ Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care of patient safety or create serious dysfunction to the effective running of a service.

Examples of issues that should be investigated under the Trust's Capability Procedure are set out below.

- 14.5 Any allegation of misconduct against a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset.
- 14.6 Although it is for the Trust to decide upon the most appropriate way forward having consulted NHS Resolution and their own employment law specialist. Although it is for the Trust to decide upon the most appropriate way forward having consulted NHS Resolution and their own employment law specialist, the Trust will also consult with a representative of the Medical Staff Committee/Local Negotiating Committee to determine which procedure, if any, should be followed, in the event of a dispute.

- 14.7 If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively or in addition he or she may make representations to the designated board member.

### **Action when investigations identify possible criminal acts**

- 14.8. Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. The Trust investigation (under either its Conduct or Capability Procedure) will only proceed in respect of those aspects of the case which are not directly related to the police investigation underway. The Trust will consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service will be contacted.

### **Cases where criminal charges are brought not connected with an investigation by South Devon Healthcare NHS Trust**

- 14.9. There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, the Trust, having considered the facts, will need to consider whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The Trust will have to give serious consideration to whether the employee can continue in their job once criminal charges have been made. Bearing in mind the presumption of innocence, the Trust will consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present job, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice will be sought from the Trust's legal adviser. The Trust will explain the reasons for taking any such action to the practitioner concerned.

### **Dropping of charges or no court conviction**

- 14.10 When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but the employer feels there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to ensure that the individual concerned does not pose a risk to patient safety. Similarly where there are insufficient grounds for bringing charges or the court case is withdrawn there may be grounds for considering police evidence where the allegations would, if proved, constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned. Where charges are dropped, the presumption is that the employee will be reinstated.

## Terms of Settlement on Termination of Employment

14.11. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following principles will be used by the Trust in such circumstances:

- Settlement agreements must not be to the detriment of patient safety.
- It is not acceptable to agree any settlement that precludes either appropriate investigations being carried out and reports made or referral to the appropriate regulatory body.
- Payment will not normally be made when a member of staff's employment is terminated on disciplinary grounds or following the resignation of the member of staff.
- Expenditure on termination payments must represent value for money. For example, the Trust should be able to defend the settlement on the basis that it could conclude the matter at less cost than other options. A clear record must be kept, setting out the calculations, assumptions and rationale of all decisions taken, to show that the Trust or authority has taken into account all relevant factors, including legal advice. The audit trail must also show that the matter has been considered and approved by the remuneration committee and the Board. It must also be able to stand up to district auditor and public scrutiny.
- Offers of compensation, as an inducement to secure the voluntary resignation of an individual, must not be used as an alternative to the disciplinary process.
- All job references must be accurate, realistic and comprehensive and under no circumstance may they be misleading.
- Where a termination settlement is agreed, details may be confirmed in a Deed of Compromise that should set out what each party may say in public or write about the settlement. The Deed of Compromise is for the protection of each party, but it must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an open reference. For the purposes of this paragraph, an open reference is one that is prepared in advance of a request by a prospective employer.

## 15 Procedure for Dealing with Issues of Capability

### *Introduction and General Principles*

- 15.1 There will be occasions where the Trust considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues.
- 15.2 Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from NHS Resolution will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, **the matter must be referred to NHS Resolution before the matter can be considered by a capability panel** (unless the practitioner refuses to have his or her case referred). The Trust will also involve NHS Resolution in all other potential disciplinary cases.
- 15.3. Matters which fall under the Trust's capability procedures include:

- ◆ Out of date clinical practice;
- ◆ Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- ◆ Incompetent clinical practice;
- ◆ Inability to communicate effectively with colleagues and/or patients;
- ◆ Inappropriate delegation of clinical responsibility;
- ◆ Inadequate supervision of delegated clinical tasks;
- ◆ Ineffective clinical team working skills.

This is not an exhaustive list.

- 15.4. Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. NHS Resolution will be consulted for advice to support the remediation of a doctor or dentist.

### **How to proceed where conduct and capability issues involved**

- 15.5. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. Although it is for the Trust to decide upon the most appropriate way forward having consulted NHS Resolution and their own employment law specialist, the Trust will also consult with a representative of the Medical Staff Committee/Local Negotiating Committee to determine which procedure, if any, should be followed, in the event of a dispute. The practitioner is also entitled to use the Trust's grievance procedure if they consider that the case has been incorrectly classified. Alternatively, or in addition he or she may make representations to the designated board member.

## Duties of Employers

- 15.6. The procedures set out below are designed to cover issues where a doctor's or dentist's *capability* to practise is in question. Prior to instigating these procedures, the employer will consider the scope for resolving the issue through counselling or retraining and will take advice from NHS Resolution.
- 15.7. The Trust will work with The relevant University to ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts.
- 15.8. Capability may be affected by ill health and this will be considered in any investigation.
- 15.9. The Trust will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds.
- 15.10. The Trust will ensure that managers and case investigators receive appropriate and effective training in the operation of this procedure. Those undertaking investigations or sitting on capability or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board will agree what training staff and Board members must have completed before they can take a part in these proceedings.

## The pre-hearing process

- 15.11. When a report of the Trust investigation has been received, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.
- 15.12. The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of NHS Resolution. The case manager will need to consider urgently:
  - Whether action under Part 2 of the procedure is necessary to exclude the practitioner; or
  - To place temporary restrictions on their clinical duties.

The case manager will also need to consider with the Medical Director and Director of Workforce & OD whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to NHS Resolution for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The case manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments.

- 4.13. NHS Resolution will assist the Trust in drawing up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by NHS Resolution, but the advice of its assessment panel is that the

practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

- 4.14. If the practitioner does not agree to the case being referred to NHS Resolution, a panel hearing will normally be necessary.
- 4.15. If a capability hearing is to be held, the following procedure will be followed beforehand:

- The case manager must notify the practitioner in writing of the decision to arrange a capability hearing, at least 20 working days in advance. Notification must include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so choose;
- All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing;
- Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not less than 30 working days), to proceed with the hearing in the practitioner's absence, although the Trust will act reasonably in deciding to do so, taking into account any comments made by the practitioner;
- Should the practitioner's ill health prevent the hearing taking place the Trust will implement its usual absence procedures and involve the Occupational Health Department as necessary;
- Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman will invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel will reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing;
- If witnesses who are required to attend the hearing choose to be accompanied, the accompanying person cannot participate in the hearing.



## The hearing framework

- 15.16. The capability hearing will be chaired by an Executive Director of the Trust. The panel will comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust. The Trust will agree the external medical or dental member with the Chair of the Medical Staff Committee.
- 15.17. No member of the panel or advisers to the panel should have been previously involved in carrying out the investigation. [In the case of clinical academics a further panel member may be appointed in accordance with [name of any protocol] agreed between the employer and the university.]
- 15.18. Arrangements must be made for the panel to be advised by:

- A senior member of staff from medical workforce, and
- A senior clinician from the same or similar clinical specialty as the practitioner concerned, but from another NHS employer;
- [A representative of a university if provided for in any protocol]

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

- 15.19. It is for the Trust to ultimately decide upon the membership of the panel. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The Trust must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

## Representation at capability hearings

- 15.20. The practitioner will be given every reasonable opportunity to present his or her case, although the hearing should not be conducted in a legalistic or excessively formal manner.
- 15.21. The practitioner may be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not be representing the practitioner formally in a legal capacity. The 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.

## Conduct of the capability hearing

15.22. The hearing should be conducted as follows:

- The panel and its advisers, the practitioner, his or her representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- The Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
- The procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:
  - The witness to confirm any written statement and give any supplementary evidence;
  - The side calling the witness can question the witness;
  - The other side can then question the witness;
  - The panel may question the witness;
  - The side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

15.23. The order of presentation shall be:

- The Case Manager presents the management case including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave;
- The Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.
- The practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave;
- The Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification;
- The Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- The Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation;
- The panel shall then retire to consider its decision.

### *Decisions*

15.24. The panel will have the power to make a range of decisions including the following:

- No action required;
- Oral agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved [stays on the employee's record for 6 months];
- 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 [stays on the employees' record for 1 year];
- 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 [stays on the employee's record for 1 year];
- Termination of contract.

Note: It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the employer that the panel wishes to comment upon.

15.25. A record of oral agreements and written warnings should be kept on the practitioner's personnel file but will be removed following the specified period.

15.26. The decision of the panel will be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Because of the complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.

15.27. The decision must be confirmed in writing to the practitioner. This notification must include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

### **Appeals in Capability Cases**

15.28. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel in arriving at their decision acted fairly and reasonably based on:

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

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not rehear the case in its entirety (but in certain circumstances it may order a new hearing see 4.30).

15.29. A dismissed practitioner will potentially be able to take their case to an Employment Tribunal where the reasonableness of the Trust's actions can be tested.

### **The appeal process**

15.30. The predominant purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the hearing panel. The appeal panel has the power to confirm or vary the decision made at the capability hearing, or order that the case is reheard. Where it is clear in the course of the appeal hearing that the proper procedures have not been followed and the appeal panel determines that the case needs to be fully re-heard, the Chairman of the panel shall have the power to instruct a new capability hearing.

15.31. Where the appeal is against dismissal, the practitioner should not be paid during the appeal, if it is heard after the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to rehear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and paid backdated to the date of termination of employment.

### **The appeal panel**

15.32. The panel will consist of three members. The members of appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, for example they must not have acted as the designated board member. These members will be:

- An independent member (trained in legal aspects of appeals) from an approved pool. This person will be appointed from the national list held by *NHS Employers* for this purpose (see Annex A to 'Maintaining High Professional Standards in the Modern NHS'). This person is designated Chairman;
- The Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- A medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust who must also have the appropriate training for hearing an appeal. The Trust will agree the external medical or dental member with the Chair of the Medical

Staff Committee.

- [In the case of clinical academics a further panel member may be appointed in accordance with [name of protocol] agreed between the employer and the university.]

15.33. The panel should call on others to provide specialist advice. This will include:

- A consultant from the same specialty or subspecialty as the appellant, but from another NHS employer. Where the case involves a dentist this may be a consultant or an appropriate senior practitioner;
- A senior human resources specialist who may be from another NHS organisation.

It is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. If for any reason the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question will be asked to provide advice.

15.34 The Trust should make the arrangements for the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 4.35. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner.

It may be necessary to postpone the hearing while this matter is resolved. The Trust must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

15.35. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability hearing. The following timetable will apply in all cases:

- Appeal by written statement to be submitted to the designated appeal point (normally the Director of Workforce & OD) within 25 working days of the date of the written confirmation of the original decision;
- Hearing to take place within 25 working days of date of lodging appeal;
- Decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

15.36. The timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The case manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

### **Powers of the appeal panel**

- 15.37. The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.
- 15.38. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.
- 15.39. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be reheard, on the basis of the new evidence, by a capability hearing panel.

### **Conduct of appeal hearing**

- 15.40. All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence.
- 15.41. The practitioner may be represented in the process by a friend, partner or spouse, colleague or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.
- 15.42. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.
- 15.43. The panel, after receiving the views of both parties, shall consider and make its decision in private.

### **Decision**

- 15.44. The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the Trust's case manager such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There shall be no correspondence on the decision of the panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it should be sought in writing from the Chairman of the appeal panel.

### **Action following hearing**

- 15.45. Records must be kept, including a report detailing the capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the capability procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Employment Tribunal.

### **Termination of Employment with Performance Issue Unresolved**

- 15.46. Where an employee leaves employment before disciplinary procedures have been completed, any outstanding disciplinary investigation will be concluded and capability proceedings will be completed where possible.
- 15.47. Where employment ends before investigation or proceedings have been concluded, every reasonable effort will be made to ensure the former employee remains involved in the process. If contact with the employee has been lost, the Trust will invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The Trust will make a judgement, based on the evidence available, as to whether the allegations about the practitioner's capability are upheld. If the allegations are upheld, the Trust will take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children Act List (held by the Department for Education and Skills).
- 15.48. If an excluded employee or an employee facing capability proceedings becomes ill, they will be subject to the Trust's [name of sickness absence procedures]. The sickness absence procedures take precedence over the capability procedures and the Trust will take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the Occupational Health Service. The Occupational Health Service will advise the Trust on the expected duration of the illness and any consequences it may have for the capability process and will also be able to advise on the employee's capacity for future work, as a result of which the Trust may wish to consider retirement on health grounds. Should employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the Trust form a judgement as to whether the allegations are upheld.
- 15.49. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner will have the opportunity to submit written submissions and/or have a representative attend in his or her absence.

## 16 HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH

### Introduction

- 16.1. A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress.
- 16.2. The Trust's key principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS.

### Retaining the services of individuals with health problems

- 16.3. Wherever possible the Trust will attempt to continue to employ individuals provided this does not place patients or colleagues at risk. In particular, the Trust will consider the following actions for staff with ill-health problems:

- Sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- Remove the practitioner from certain duties;
- Reassign them to a different area of work;
- Arrange re-training or adjustments to their working environment, with appropriate advice from NHS Resolution and/or deanery, under the reasonable adjustment provisions in the Disability Discrimination Act 1995 (DDA).

This is not an exhaustive list

### Reasonable adjustment

- 16.4. At all times the practitioner will be supported by the Trust and the Occupational Health Service (OHS) which will ensure that the practitioner is offered every available resource to get back to practise where appropriate. The Trust will consider what reasonable adjustments could be made to their workplace or other arrangements, in line with the DDA. In particular, it will consider:

- Making adjustments to the premises;
- Re-allocating some of a disabled person's duties to another;
- Transferring an employee to an existing vacancy;
- Altering an employee's working hours or pattern of work;
- Assigning the employee to a different workplace;
- Allowing absence for rehabilitation, assessment or treatment;
- Providing additional training or retraining;
- Acquiring/modifying equipment;
- Modifying procedures for testing or assessment;
- Providing a reader or interpreter;
- Establishing mentoring arrangements.



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

### **Handling Health Issues**

- 16.6. Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine a health problem. If the report recommends OHS involvement, the nominated manager must immediately refer the practitioner to a qualified occupational physician (usually a consultant) with the Occupational Health Service.
- 16.7. NHs Resolution should be approached to offer advice on any situation and at any point where the employer is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.
- 16.8. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of Workforce & OD, the Medical Director or case manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.
- 16.9. If a doctor or dentist'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 and referral to the professional regulatory body must be considered, irrespective of whether or not they have retired on the grounds of ill health.
- 16.10. In those cases where there is impairment of performance solely due to ill health, disciplinary procedures will be considered only in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by repeatedly refusing a referral to the OHS or NHS Resolution. In these circumstances the procedures section 15 should be followed.
- 16.11. There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

## **17 Training and Awareness**

- 17.1 Advice and support will be provided by Medical Workforce to support staff and managers in adhering to this policy

## **18 Contact Details**

- 18.1 Any queries regarding this policy should be directed to Medical Workforce of the Directorate of Workforce and Organisational Development.

- [sdhct.medicalhr@nhs.net](mailto:sdhct.medicalhr@nhs.net)

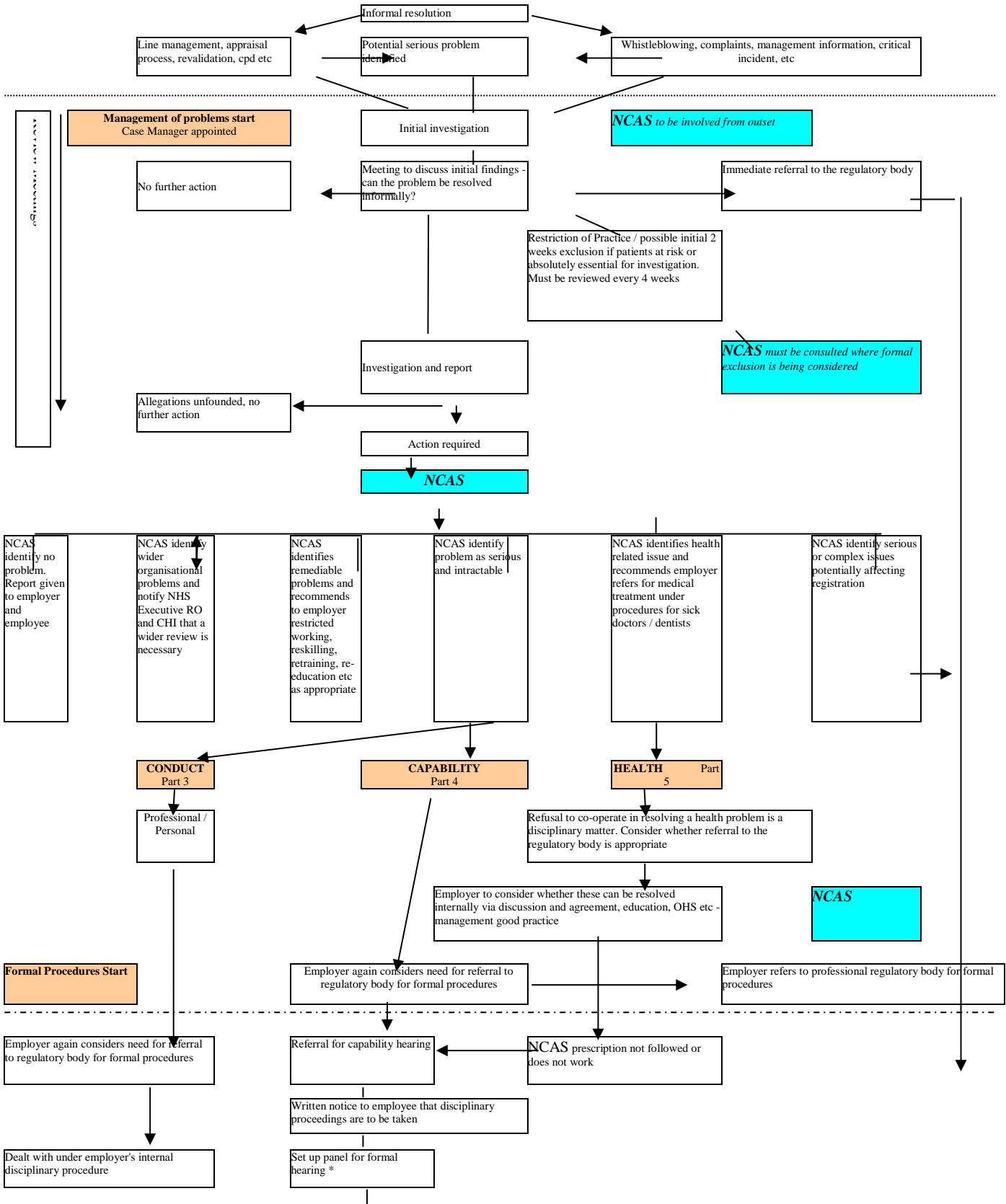
## **19 Appendix 1 – Summary of the Rights of a practitioner under the Policy for Maintaining High Professional Standards for Medical and Dental Staff**

If a practitioner is subject to action under the Policy for Maintaining High Professional Standards for Medical and Dental Staff his/her rights are:

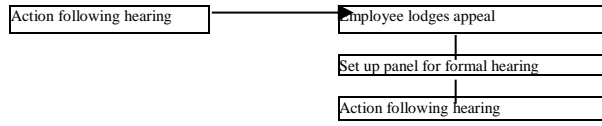
1. To be accompanied and/or represented from the outset, by either an accredited representative of a trade union or a defence organisation, or another employee of the NHS, friend, partner or spouse. Sufficient time will be allowed for the representative or companion to offer advice and prepare the case. The companion may be legally qualified but 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.
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 which is retained on employees personal file.
5. To be reminded in writing of his/her right of appeal in matters classed as serious or gross misconduct
6. Entitlement to all information relating to the allegations.

Any investigative report commissioned by the MD remains the property of the Trust. 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.

## 20 Appendix 2 – Proposed Management of Performance Problems and Disciplinary Procedure



MD 29 – Maintaining High Professional Standards in the NHS



#Where a case relates to a trainee grade doctor/dentist the Postgraduate Dean (or his/her representative) must be involved. \*Where a clinical judgement is required a senior member of the medical staff at the NHS trust should be involved

Contact NCAS for advice

Exclusion should only be used: > when >  
patient or staff safety is threatened  
to protect the individual being investigated:  
or > to ensure a thorough and unhindered  
investigation can take place.

## 21 Appendix 3 – Actions to be undertaken At Different Stages of Exclusion

Stage	Action
<p>First and Second reviews (and reviews after the third review)</p>	<p>Before the end of each exclusion (of up to 4 weeks) the case manager reviews the position.</p> <ul style="list-style-type: none"> <li>◆ The case manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time.</li> <li>◆ Case Manager submits advisory report of outcome to Chief Executive and the Board.</li> <li>◆ Each renewal is a formal matter and must be documented as such.</li> <li>◆ The practitioner must be sent written notification on each occasion.</li> </ul>
<p>Third Review</p>	<p>If the practitioner has been excluded for three periods:</p> <ul style="list-style-type: none"> <li>◆ A report must be made to the Chief Executive: <ul style="list-style-type: none"> <li>Outlining the reasons for the continued exclusion and why the restrictions on practice would not be an appropriate alternative.</li> <li>And if the investigation has not been completed a timetable for completion of the investigation.</li> </ul> </li> <li>◆ The CE must report to the CCG and the designate Board Member.</li> <li>◆ The case must formally be referred to NHS Resolution explaining: <ul style="list-style-type: none"> <li>Why continued exclusion is appropriate</li> <li>What steps are being taken to conclude the exclusion at the earliest opportunity</li> </ul> </li> <li>◆ NHS Resolution will review the case with the CCG and advise the NHS body on the handling of the case until it is concluded.</li> </ul>
<p>6 months review</p>	<p>If the exclusion has been extended over six months:</p> <ul style="list-style-type: none"> <li>◆ A further position report must be made by the CE to the CCG indicating: <ul style="list-style-type: none"> <li>The reasons for continuing exclusion</li> <li>Anticipated timescale for completing the process</li> <li>Actual and anticipated costs of the exclusion</li> </ul> </li> </ul> <p>The CCG will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether this is any advice they can offer to the Board.</p>

