Shropshire Community Health NHS
NHS Trust

Policies, Procedures, Guidelines and Protocols

Document Details	
Title	**Maintaining High Standards of Performance – Medical and Dental staff**
Trust Ref No	719-59039
Local Ref (optional)	
Main points the document covers	This policy details the arrangements for managers to deal with issues of conduct and capability with regard to medical and dental staff.
Who is the document aimed at?	All medical and dental staff and managers who have line management responsibilities for those staff.
Author	Gina Billington, HR Manager
Approval process	
Who has been consulted in the development of this policy?	Joint Local Negotiating Committee Consultant group
Approved by (Committee/Director)	HR & Workforce Group
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Other	None

Amendments History		
No	Date	Amendment
1	Dec 2015	Replaces former PCT Policies
2	Nov 2019	Updated to reflect change of name from NCAS to PPA. Removal of section 4 as duties and responsibilities are clear throughout the document. Replaced the words 'the Trust' with appropriate pronouns to aid reading of the document.
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Contents

1.0 Introduction

1.1 We are committed to encouraging, engaging and supporting staff to perform to the best of their ability. This policy outlines the 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.

1.2 The approach set out in this Policy builds on key elements:

- Appraisal and revalidation - processes which encourage practitioners to maintain the skills and knowledge needed for their work through continuing professional development;
- The advisory and assessment services of the Practitioner Performance Advice [a service provided by NHS Resolution] (formerly the National Clinical Assessment Service (NCAS) – there to help us to handle cases quickly and fairly, and reduce the need to use disciplinary procedures to resolve problems;

1.3 Our approach recognises the importance of seeking to tackle performance issues through training, or other remedial action, rather than through disciplinary action alone.

1.4 Our policy aims to establish a clear and co-ordinated process for handling concerns relating to the safety of patients and staff posed by the conduct and/or performance of doctors and dentists, which comes to our attention. Whatever the source of this information, we will:

- Ascertain quickly what has happened and why.
- Assess whether there is a continuing risk.
- Decide whether immediate action is needed to remove the source of the risk.
- Establish actions to address any underlying problem.

1.5 Our policy also sets out clear processes, within the national framework, for handling disciplinary issues relating to doctors and dentists. These include dealing with issues of Misconduct and Capability, and handling concerns relating to a practitioner's health.

1.6 Our policy aims to ensure that all Medical and Dental staff are aware of:

- the expectation to perform their duties in adherence to our policies and procedures
- the standards of performance required including the requirement to follow all reasonable management instructions
- the requirement to ensure their conduct is at all time appropriate
- how they will be helped to achieve improvements in their conduct or performance if necessary

1.7 The Policy also provides a clear framework for managers to apply when:

- informal approaches have failed to resolve unacceptable conduct or performance
- informal approaches are inappropriate because of the seriousness of the situation.

2.0 Guiding principles

2.1 In the handling of concerns relating to the conduct and performance of doctors and dentists, the following guiding principles will always apply:

- We recognise that unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. All allegations, including those made by relatives of patients, or concerns raised by colleagues, will be carefully

considered and, if required, properly investigated to verify the facts, so that the allegations may be shown to be true or false.

- We will always try to resolve issues as informally as possible, where such issues are not of a serious nature.
- Exclusion from work will be used only in the most exceptional of circumstances, and the exclusion of a practitioner will not be viewed as a solution in itself. Periods away from work will be kept to the minimum, through effective performance management arrangements. We will ensure that progress with an investigation is maintained and the need for continued exclusion is frequently reviewed.
- We will consult with the Practitioner Performance Advice (PPA) at an early stage, when action in relation to clinical concerns is being considered, and on a regular basis as a case is progressing. Our intention is that the early intervention of PPA will help us to maintain momentum in resolving concerns about clinical competence, and reduce the period of exclusion from the workplace for long periods of time.
- We will work with the PPA to ensure that, wherever possible, alternatives to exclusion are considered.
- Concerns relating to the Capability of doctors and dentists in training should be considered as training issues, and the Postgraduate Dean will be involved from the outset

Confidentiality

2.2 We and our 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.

2.3 We will only confirm publicly that an investigation or disciplinary hearing is underway.

2.4 Personal data released to the case investigator for the purposes of investigation will be consistent with the guiding principles of the Data Protection Act.

2.5 We will:

- ensure those authorised to take disciplinary action at the appropriate stages are trained and competent
- differentiate between matters of performance and conduct wherever possible
- ensure proper adherence to policy throughout the procedure by involving a Head of HR / Human Resources (HR) Manager.

2.6 The Manager will:

- deal with disciplinary matters in a sensitive manner which does not discriminate.
- seek the advice of a Head of HR / HR Manager at the earliest stages (including any informal processes)
- make sure their staff are aware of this policy and the procedures contained within
- ensure written records are kept confidential

2.7 All Medical and Dental staff will:

- perform their duties within with rules and contractual obligations
- treat colleagues, patients and visitors with honesty, respect and dignity, reflecting our values
- be honest and trustworthy
- be co-operative and act reasonably
- report the facts of any criminal charges not related to work (with the exception of minor motoring offences) to their manager and subsequently advising them of the outcome i.e. charges dropped, conviction or discharge (absolute or conditional)

Explanations of terms

2.8 **Conduct –** The broader meaning of conduct means the way you behave at work, your attitude, and how you go about your work in accordance with the rules of the Trust and reasonable requests made by your manager

2.9 **Performance** – Relates to how capable you are of doing your job and how well you are performing to the required standards / quality agreed by you and your manager.

2.10 **Practitioners Performance Advice** works to resolve concerns about the practice of doctors, dentists and pharmacists by providing case management services to health care organisations and to individual practitioners. Contact details are as follows:

https://resolution.nhs.uk/services/practitioner-performance-advice/

Phone: 020 7811 2600

Email: advice@resolution.nhs.uk

GMC. General Medical Council.
GDC. General Dental Council.
JLNC. Joint Local Negotiating Committee

3.0 Action when a concern arises

3.1 Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:

- from other NHS professionals, health care managers, students and non-clinical staff;
- a review of performance against job plans, annual appraisal, revalidation;
- monitoring 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;
- Serious Incident Requiring Investigation (SIRI) reports;
- information from the regulatory bodies;
- litigation following allegations of negligence;
- information from the police or coroner;
- court judgements.

3.2 Concerns about the capability of doctors and dentists in training will be considered initially as training issues and the Clinical Tutor and also the trainees' education supervisor will be informed in the first instance. The Clinical Tutor will then be responsible for informing the Postgraduate Dean of any confirmed concerns at the outset.

3.3 All serious concerns must be registered with the Chief Executive and they will ensure that a case manager is appointed – this is usually the Medical Director. The Chair of the Board will designate a Non-Executive Director "the Designated Board Member" to oversee the case and ensure that momentum is maintained.

3.4 The Designated Board Member will ensure that the investigation is completed in a timely manner and also monitor the situation until any exclusion has been lifted to ensure the total period of exclusion is not unnecessarily prolonged. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action.

3.5 However the issue is raised, the Medical Director will need to work with the Head of Human Resources to decide the appropriate course of action in each case. The Medical Director will act as the case manager in cases involving Associate Medical Directors and consultants but may delegate this role to a senior manager to oversee the case on his or her behalf in other cases. The Medical Director is responsible for appointing a case investigator.

Right to be accompanied

3.6 At all stages of the procedure the practitioner is entitled to be accompanied at any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another member of the Trust, 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.

Exclusion

3.7 When serious concerns are raised about a practitioner, we will urgently consider whether we need to place any 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.

3.8 At any point where the case manager has reached the clear judgement 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 PPA. We will also consider whether the issue of an alert letter should be requested.

3.9 PPA has a responsibility for reporting and monitoring exclusions and suspensions and publishes the annual statistics on behalf of the Department of Health. We have an obligation to inform PPA when we exclude a doctor or dentist.

Identifying if there is a problem

3.10 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 Head of HR, the Medical Director and the PPA. PPA asks that the first approach to them should be made by the Chief Executive or Medical Director.

3.11 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 failure. Each will require appropriate investigation and remedial actions. We are committed to maintaining an open and fair culture, which encourages doctors, dentists and other staff to report adverse incidents and other near misses.

3.12 Having discussed the case with PPA, the case manager must decide whether an informal approach can be taken or whether a formal investigation will be needed. Where an informal route is chosen PPA should still be involved until the problem is resolved.

3.13 There may be potential health issues identified and the involvement of the occupational health service to support the individual should take place. We may request for advice on whether adopting a more formal route may have an adverse effect on a practitioner's health.

3.14 Where it is decided that a formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Head of HR, appoint an appropriately experienced or trained person as case investigator.

The case investigator:

3.15 Is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings.

3.16 Where no suitable senior doctor or dentist is employed by us, a senior doctor or dentist from another NHS body should be approached.

3.17 They 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.

3.18 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.

3.19 Must ensure that a detailed written record (including a timeline) is kept of the investigation, the conclusions reached and the course of action agreed by the Head of HR with the Medical Director.

3.20 Must assist the Designated Board Member in reviewing the progress of the case.

The Investigation

3.21 The case investigator does not make the decision on what action should be taken or if the employee should be excluded from work and will not be a member of any disciplinary or appeal panel relating to the case.

3.22 The practitioner concerned will be informed in writing by the case manager,

- that an investigation is to be undertaken,
- the name of the case investigator and
- the specific allegations or concerns that have been raised.

3.23 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 manager, suggest individuals who they feel should be interviewed as part of the investigation and be given the opportunity to be accompanied.

3.24 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.

3.25 If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider the need for a practitioner in the same specialty and / or grade from another NHS body to assist, bearing in mind the need to proceed speedily through the process.

3.26 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. In exceptional circumstances, it may be necessary to extend this timescale. If this happens the practitioner concerned and his / her companion will be kept informed of the delay and possible completion date. The report of the investigation should give the case manager sufficient information to make a decision on whether:

- There is a case of misconduct that should be put to a disciplinary panel;
- There are concerns about the practitioner's health that should be considered by the occupational health service;
- There are concerns about the practitioner's performance that should be further explored by Practitioners Performance Advice;
- Restrictions on practice or exclusion from work should be considered;
- There are serious concerns that should be referred to the GMC or GDC;
- No further action is needed.

Involvement of Practitioners Performance Advice following local investigation

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

3.26 The focus of PA work is 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.

3.27 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. PA may advise on this.

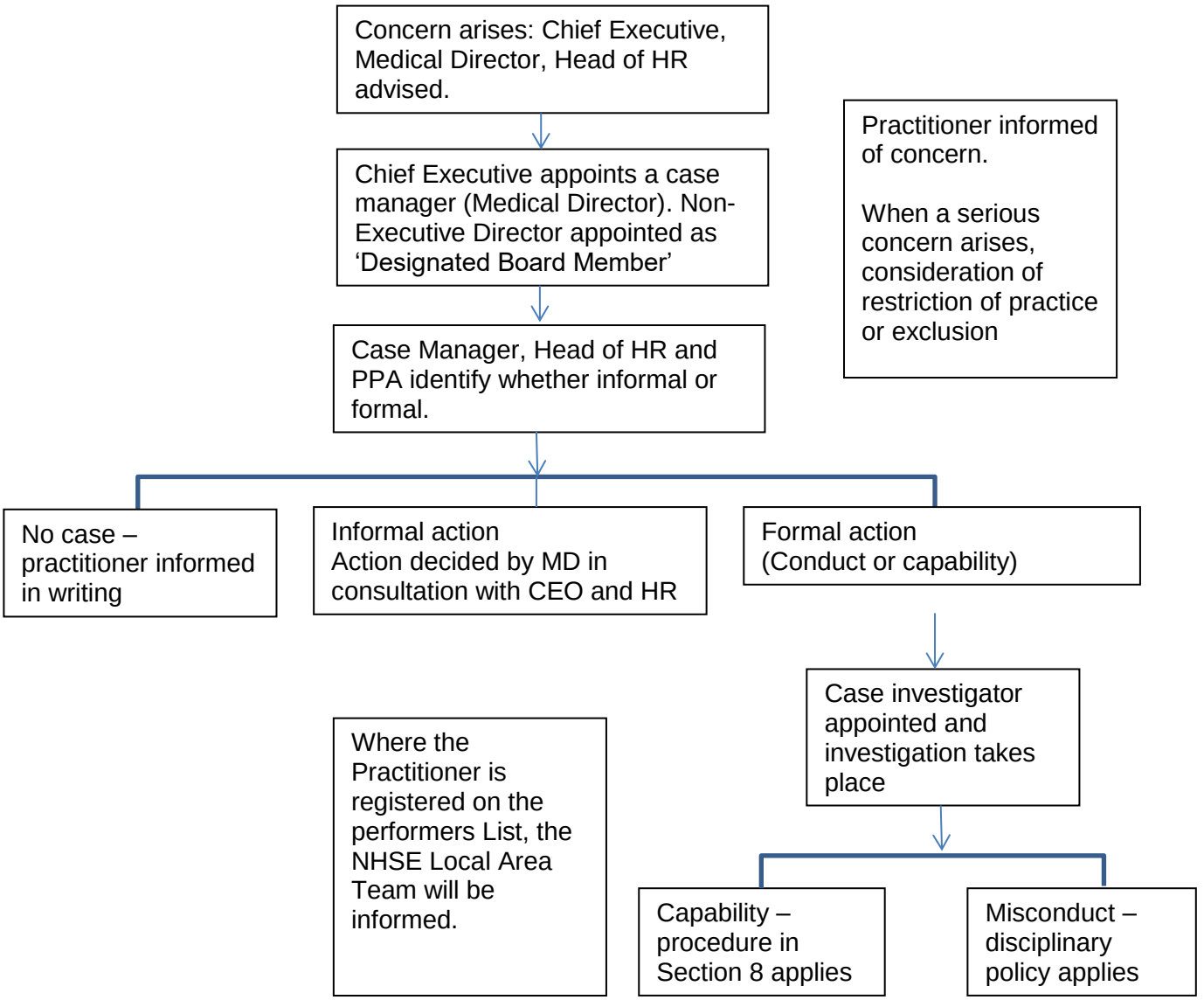
3.28 Where we are considering excluding a doctor or dentist (whether or not his or her performance is under discussion with PA), we will inform PA of this at an early stage, so that alternatives to exclusion are considered. It is particularly desirable to find an alternative when PPA is likely to be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

3.29 A practitioner undergoing assessment by PA must cooperate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the PA assessment is complete (Circular HSC 2002/011, Annex 1, paragraph 3).

3.30 Failure to co-operate with a referral to PPA may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with us 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.

Process when a Concern arises



4.0 Restriction of practice and exclusion from work

4.1 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.

4.2 We 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

4.3 When serious concerns are raised about a practitioner, we 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 when alternative courses of action are not feasible.

4.4 Exclusion of Medical and Dental staff from the workplace is a temporary measure. It is a precautionary measure and not a disciplinary sanction and will be reserved for only the most exceptional circumstances.

4.5 Exclusion will only be used:

- 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.

4.6 Alternative ways to manage risks, avoiding exclusion, include:

- Medical or Associate Medical 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. There should be clarity for both parties in all cases about the nature of the leave (i.e. there should be no confusion about sick leave versus exclusion).

4.7 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 PPA. 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 PPA, which can assess the problem in more depth and give advice on any action necessary. The case manager will seek immediate telephone advice from PPA when considering restriction of practise or exclusion.

The Exclusion Process

4.8 We will not exclude a practitioner for more than four weeks at a time. The reason for continued exclusion will 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

4.9 The Chief Executive has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by persons nominated under paragraph 5.12. The case will be discussed fully with the Chief Executive, the Medical Director, the Head of HR, PPA 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.

4.10 The authority to exclude a member of staff is vested in the Chief Executive, Medical Director and the Clinical Directors of the Trust.

4.11 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 the Designated Board Member

4.12 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. 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

4.13 In exceptional circumstances, an immediate time-limited exclusion may be necessary for the purposes identified in paragraph 6.5 above following:

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

4.14 Such an exclusion will allow a more measured consideration to be undertaken. PPA should be contacted before the immediate exclusion takes place. This period should be used to carry out a preliminary analysis, to seek further advice from PPA and to convene a case conference. The practitioner will be informed why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and a date agreed 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 the right to be accompanied.

Formal exclusion

4.15 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. PPA 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.

4.16 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.

4.17 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 capability or poor performance of sufficient severity; or

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

4.18 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.

4.19 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 PPA with voluntary restriction).

4.20 The formal exclusion will be confirmed in writing as soon as is reasonably practical. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion and that a full investigation 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.

4.21 In cases where 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.

4.22 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 PPA 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.

4.23 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, inform the NHS Commissioning Board and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

4.24 There are no other forms of exclusion other than those laid down in this policy.

Exclusion from the Premises

4.25 Practitioners should not be automatically barred from the premises upon exclusion from work. Case managers 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. Consideration should be given to whether it would be appropriate for the practitioner 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.

Keeping in Contact

4.26 Exclusion under this policy will usually be on full pay; and 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) that they may 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 will 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).

4.27 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 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 Organisation's

4.28 In cases where there is concern that the practitioner may be a danger to patients, we have an obligation to inform 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 we have placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

4.29 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 Medial Director of the Regional Office of the NHS Commissioning Board to consider the issue of an alert letter.

Keeping Exclusions under Review: Informing the Board

4.30 The Board must be informed about exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

- require a summary of the progress of each case at the end of each period of exclusion, 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;
- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended.

Regular review

4.31 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. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon their employment, as soon as 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.

4.32 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; the Designated Board Member will not sit as a member of any future disciplinary or appeal panel. 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.

4.33 We will take review action before the end of each four-week period. After three exclusions, PPA will be notified. The information below outlines the activities that must be undertaken at different stages of exclusion.

4.34 We will use the same timeframes and procedures to review any restrictions on practice, although the requirements for reporting to the Board do not apply in these circumstances.

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

4.35 Before the end of each exclusion period (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 the 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

4.36 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 Designated Board Member;

- The case must be reported to PPA explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion, at the earliest opportunity;
- PPA will advise us on the handling of the case until it is concluded.

Six months review

4.37 If the exclusion has been extended over six months:

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

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

Return to Work

4.39 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.

The role of the Board

4.40 Board members may be required to sit as members of a disciplinary or appeal panel. 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.

4.41 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.

4.42 This Designated Board 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.

5.0 Conduct and disciplinary matters

5.1 Misconduct matters for doctors and dentists, as for all other staff groups, are dealt with under our Disciplinary Policy. However, where any concerns about the performance or conduct of a medical practitioner are raised, we will contact PPA for advice before proceeding.

5.2 Where the alleged misconduct being investigated 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 disciplinary 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 us. We will agree the selection of the medical or dental panel member with our Joint Local Negotiating Committee chair.

5.3 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 Clinical Tutor / Director of Medical Education with close involvement of the Postgraduate Dean from the outset.

5.4 Although we will decide on the most appropriate way forward having consulted PPA and their own employment law specialist, we will also consult with chair of the Joint Local Negotiating Committee to determine which procedure (conduct vs capability), if any, should be followed, in the event of a dispute.

5.5 If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use our grievance procedure. Alternatively or in addition he or she may make representations to the Designated Board Member.

Action when investigations identify possible criminal acts

5.6 Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police and a referral made to the GMC / GDC. Our investigation (under either its Disciplinary or Capability Procedure) will only proceed in respect of those aspects of the case which are not directly related to the police investigation underway. We 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 the Trust

5.7 There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, the Trust will, 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. We will 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, we 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 our legal adviser. We will explain the reasons for taking any such action to the practitioner concerned. The matter will also be referred to the GMC / GDC.

Dropping of charges or no court conviction

5.8 When we have refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but we feel there is enough evidence to suggest a potential danger to patients, then we have a public duty to take action to ensure that the individual concerned does not pose a risk to patient safety. Again, this will include referral to the GMC / GDC. 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 will be made clear to the police that any evidence they provide and is used in our 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.

6.0 Procedure for dealing with issues of capability

Introduction and General Principles

6.1 There will be occasions where we consider 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.

6.2 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. Initial advice will always be sought from PPA as an integral part of the process to help us 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 case must be discussed with PPA and consideration given to referral for further assessment by PPA (unless the practitioner refuses to have his or her case referred in this way). We will also involve PPA in all other potential disciplinary cases.

6.3 Matters which fall under our 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.

6.4 Wherever possible, we 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. PPA will be consulted for advice to support the remediation of a doctor or dentist.

How to proceed where conduct and capability issues are involved

6.5 It is inevitable that some cases will cover conduct and capability issues. We recognise 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 us to decide upon the most appropriate way forward having consulted PPA and their own employment law specialist, we will also consult with the Chair of the 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 our grievance procedure if they consider that the case has been incorrectly classified. Alternatively, or in addition, they may make representations to the Designated Board Member.

Duties of Employers

6.6 The procedures set out below are designed to cover situations where a doctor's or dentist's capability to practise is in question. Prior to instigating these procedures, we will consider the scope for resolving the issue through counselling or retraining and will take advice from PPA.

6.7 Capability may be affected by ill health and this will be considered in any investigation. Arrangements for handling concerns about a practitioner's health are described in part 9 of this procedure.

6.8 We will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of disability, sensory impairment, faith or belief, ethnicity, gender, sexual orientation, transgender status or age.

6.9 We will ensure that medical 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 Equality and Inclusion 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

6.10 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 can be extended.

6.11 Where the investigation report identifies a capability issue, 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 PPA. The case manager will need to consider urgently:

- Whether action under Section 6 of the procedure is necessary to exclude the practitioner; or
- To place temporary restrictions on their clinical duties.

6.12 The case manager will also need to consider with the Medical Director and Head of People 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 the PPA 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.

6.13 PPA will assist us in drawing up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. We will facilitate the agreed action plan (which has to be agreed by us and the practitioner before it can be implemented). There may be occasions when a case has been considered by PPA, 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 PPA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

6.14 If the practitioner does not agree to the case being referred to PPA, a panel hearing will normally be necessary.

6.15 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. This notification should be made at least 20 working days before the hearing and include details of the allegations and the stage the hearing represents in the disciplinary process, the date, time and venue of the hearing, the names and job titles of those hearing and assisting at the disciplinary hearing, the arrangements for proceeding including the practitioner's rights to be accompanied and to present evidence/ call witnesses, the names of any witnesses to be summoned 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. We retain the right, after a reasonable period (not less than 30 working days), to proceed with the hearing in the practitioner's absence, although we 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 we will implement our usual absence procedures and involve the Occupational Health Service 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

6.16 The capability hearing will be chaired by an Executive Director of the Trust. The panel will comprise a total of three people, normally two 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 us. We will agree the external medical or dental member with the Chair of the Joint Local Negotiating Committee.

6.17 No member of the panel or advisers to the panel should have been previously involved in carrying out the investigation.

6.18 Arrangements must be made for the panel to be advised by:

- A senior member of staff from Human Resources, and
- A senior clinician (medical or dental practitioner, as appropriate) from the same or similar clinical specialty as the practitioner concerned, but from another NHS employer.

6.19 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.

6.20 The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. We 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. We will provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

Representation at capability hearings

6.21 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.

6.22 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

6.23 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 that called the witness may seek to clarify any points, which have arisen during questioning but may not at this point raise new evidence.

6.24 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

6.25 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 (for concerns not addressed by an oral agreement or of a more serious nature) 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 (for concerns not addressed by a first written warning or of a more serious nature) 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 (for concerns not addressed by a final written warning or of a more serious nature).

6.26 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 issues concerning the systems and procedures operated by the employer that the panel wishes to comment upon.

6.27 A record of oral agreements and written warnings should be kept on the practitioner's personnel file. The length of time the warning remains "live" on the practitioner's personnel file, and can be referred to in subsequent disciplinary action, is as stated in 8.23.

6.28 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.

6.29 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

6.30 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 our 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.

6.31 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 re-hear the case in its entirety (but in certain circumstances it may order a new hearing see 8.32).

6.32 A dismissed practitioner will potentially be able to take their case to an Employment Tribunal where the reasonableness of our actions can be tested.

The appeal process

6.33 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 re-heard. 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.

6.32 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 have their pay backdated to the date of termination of employment. Where the decision is to re-hear the case, the practitioner should also be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and pay backdated to the date of termination of employment.

The appeal panel

6.33 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 us who must also have the appropriate training for hearing an appeal.

We will agree the external medical or dental member with the Chair of the Local Negotiating Committee.

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

- A senior clinician 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.

6.35 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.

6.36 We will make the arrangements for the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 8.38. This notification should include the date, time and venue of the hearing, the names and job titles of those hearing and assisting at the appeal, 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 appeal panel.

6.37 The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. We 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. We must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

6.38 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 Head of HR) 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 to us within 5 working days of the conclusion of the hearing.

6.39 The timetable will be agreed between us 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

6.40 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.

6.41 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.

6.42 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 re-heard, on the basis of the new evidence, by a capability hearing panel.

Conduct of appeal hearing

6.43 All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence.

6.44 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.

6.45 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.

6.46 The panel, after receiving the views of both parties, shall consider and make its decision in private.

Decision

6.47 The decision of the appeal panel shall be made in writing to the appellant and shall be copied to the case manager so 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

6.48 Clear written 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. 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

6.49 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.

6.50 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, we 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). We 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, we 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).

6.51 If an excluded employee or an employee facing capability proceedings becomes ill, they will be subject to the our Managing Attendance Policy. The sickness absence procedures take precedence over the capability procedures and we will take reasonable steps to give the employee time to recover and attend any hearing. Where the

employee's illness exceeds 4 weeks, they will be referred to the Occupational Health Service. The Occupational Health Service will advise the us 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 we 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 we will form a judgement as to whether the allegations are upheld.

6.51 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.

6.53 Where a case involves allegations of abuse against a child, the guidance issued to the NHS in September 2000, called "The Protection of Children Act 1999 – A Practical Guide to the Act for all Organisations Working with Children" gives more detailed information. A copy can be found on the Department of Health website *www.dh.gov.uk/PublicationsAndStatistics*).

7.0 Handling concerns about a practitioner's health

7.1 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.

7.2 Our 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

7.3 Wherever possible we will attempt to continue to employ individuals provided this does not place patients or colleagues at risk. In particular, we 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 PPA and/or Deanery. Under the Equality Act 2010 an employer has a duty to make reasonable adjustments.

This is not an exhaustive list.

Reasonable adjustment

7.4 At all times the practitioner will be supported by us and our Occupational Health Service which will ensure that the practitioner is offered every available resource to get back to practise where appropriate. We will consider what reasonable adjustments could be made to their workplace or other arrangements, in line with the Equality Act (2010). 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.

7.5 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

7.6 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 Occupational Health Service involvement, the nominated medical manager must immediately refer the practitioner to the Occupational Health Service.

7.7 PPA 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.

7.8 The occupational health physician should agree a course of action with the practitioner, send his / her recommendations to the Medical Director and a meeting should be convened with the Head of HR, the Medical Director or case manager, the practitioner and case worker from the Occupational Health Service to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to be accompanied at this meeting. 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.

7.9 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).

7.10 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 Occupational Health Service or PPA .

7.11 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 we will refer the doctor or dentist to the Occupational Health Service for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the Occupational Health Service under these circumstances, may give separate grounds for pursuing disciplinary action.

8.0 Monitoring compliance and effectiveness

8.1 The Policy will be regularly reviewed and maintained by the HR department.

8.2 The application of this policy will be monitored through the Medical Director's office. Adherence to the policy will be monitored through audit and also through feedback from all those involved in the process.

8.4 Reports identifying excluded doctors are required by PPA.

9.0 Related documents

9.1 The following Trust documents can be found in the policies and procedures section of the our website and should be referred to for related information:

Appraisal and Revalidation Policy for Medical Staff
Anti-Fraud, Bribery and Corruption Response Policy
Anti-Bribery Policy and Procedure
Disciplinary Policy
Equality and Diversity Policy
Managing Attendance at Work Policy

Other related documents

Maintaining High Professional Standards in the Modern NHS (MHPS)
General Medical Council Good Medical Practice
General Dental Council Standards for Dental Professionals
The National Health Service (Performers Lists) (England) Regulations 2013