Salisbury NHS
NHS Foundation Trust

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TRUST POLICY AND PROCEDURES FOR THE HANDLING OF CONCERNS ABOUT THE CONDUCT AND PERFORMANCE OF DOCTORS AND DENTISTS

Type of document

Please tick the relevant box:

Policy (must do)	X
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Version No.	Updated By	Updated On	Description of Changes
1.1	Alan Denton Director of Human Resources	10 January 2010	Minor changes to update the policy after being in use for three years, and to more closely meet Trust standards for policies (e.g. text type and size etc)

CONTENTS

3. APPEALS PANELS IN CAPABILITY ISSUES

4. EQUALITY IMPACT ASSESMENT

Policy

1.0 INTRODUCTION

1.1 Under the *Restriction of Practice and Exclusion from Work Directions 2003*, all NHS bodies must comply with the framework contained within the document *Maintaining High Professional Standards in the Modern NHS*. Initially, under cover of Health Service Circular (HSC) 2003/012, this document introduced a revised framework for:

- the initial handling and investigation of concerns about the conduct and performance of medical and dental staff, and
- the restriction of practice and exclusion from work, which replaced all existing guidance on the suspension of doctors and dentists.

1.2 The framework, developed at a national level by the Department of Health, the NHS Confederation, the British Medical Association (BMA) and the British Dental Association (BDA), applies to the NHS in England: Its provisions cover action to be taken when a concern about a doctor or dentist first arises and action to consider whether there need to be restrictions placed on a doctor's or dentist's practice or exclusion from work is considered necessary.

1.3 Developing new arrangements for handling issues relating to medical and dental staff performance had become increasingly important, both to tackle cases of inappropriate and lengthy 'suspensions' across the NHS and to reflect the new systems for quality assurance and quality improvement that had been introduced in the NHS in recent years.

1.4 The approach set out in the framework, which is reflected in this Policy, built on four 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 National Clinical Assessment Service (NCAS) - aimed at enabling Trusts to handle cases quickly and fairly, and reducing the need to use disciplinary procedures to resolve problems;

- Tackling the blame culture - recognising that many failures in standards of care are caused by systems' weaknesses, and not by individuals as such;

- Abandoning the 'suspension culture' - by introducing new arrangements for handling 'exclusion from work'.

To work effectively, these key elements need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists keeping their skills and knowledge up to date and maintaining their competence, and which support an open approach to reporting and tackling concerns about doctors' and dentists' practice.

1.5 Under HSC 2005/002, *Maintaining High Professional Standards in the Modern NHS* introduced further developments to the framework. These covered new disciplinary procedures for doctors and dentists employed by the NHS. As with those sections dealing with the initial handling of concerns, and exclusion, the sections covering disciplinary procedures were drafted in close collaboration with NHS Employers and the NCAS, with agreement from the BMA and BDA. The complete framework supercede all previous disciplinary procedures contained within HC(90)9 and HC(82)13 and abolished the right of appeal to the Secretary of State, held by certain practitioners, under paragraph 190 of their terms and conditions of service.

2.0 PURPOSE

2.1 The purpose of this revised (2010) Policy is to:

- Establish a clear and co-ordinated process for handling concerns relating to the safety of patients posed by the conduct and/or performance of doctors and dentists, which come to the attention of the Trust. Whatever the source of this information, the response will be the same, i.e. to:

  - Ascertain quickly what has happened and why.

  - Determine 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.

2.2 The Policy also sets out clear processes, again in accordance with the national framework, for handling disciplinary procedures relating to doctors and dentists. These include dealing with issues of Misconduct and Capability, and handling concerns relating to a practitioner's health.

3.0 GUIDING PRINCIPLES

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

- The Trust recognises that unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore, 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, such that the degree of veracity of the allegations may be shown.

- The Trust will **always** endeavour to resolve issues using informal processes wherever possible, where such issues are not deemed to be of a nature sufficiently serious to make a formal procedure the only appropriate option.

- Exclusion from work will be used only in exceptional circumstances, and the exclusion of a practitioner will not be viewed as a solution in itself. Furthermore, periods away from work will be kept to the minimum, through effective performance management arrangements, which will ensure that progress with an investigation is maintained and the need for continued exclusion is frequently reviewed (an exclusion will lapse and the practitioner will be entitled to return to work if the exclusion is not actively reviewed).

- When action in relation to **clinical concerns** is being considered the Trust will consult with the NCAS at an early stage, and thereafter on a regular basis whilst a case is progressing. The underlying intention is that the early intervention of the

NCAS will help the Trust to maintain momentum in resolving concerns about clinical competence, and thereby minimize the number of doctors and dentists who are excluded from their workplace for long periods of time.

- The Trust will work with the NCAS 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. The Trust's Director of Medical Education will be the point of initial contact with the Postgraduate Dean.

- The Trust supports an open approach to reporting and tackling concerns about doctors' and dentists' practice, and recognises the importance of seeking to tackle performance issues through training, or other remedial action, rather than solely through disciplinary action. Notwithstanding this approach, the provisions of this Policy are not intended to weaken accountability or avoid disciplinary action, where genuinely serious Misconduct and/or Capability issues are evident.

4.0 FORMAT

4.1 The Policy comprises five main sections, which address the following issues:

Section 1 Procedures when a Concern Arises

Section 2 Restriction of Practice and the Exclusion of Practitioners from Work

Section 3 Procedures for Dealing with Issues of Capability

Section 4 Appeals Procedure (following Capability Panel Hearings)

Section 5 Handling of Concerns relating to a Practitioner's Health

Most sections include a Process Pathway flow-chart, which aims to summarise the actions, considerations and time scales associated with each procedure. Management Instructions and Guidance are also provided as appendices.

SECTION 1

5.0 PROCEDURES WHEN A CONCERN ARISES

5.1 Identification of Performance Issues

5.1.1 The management of performance is a continuous process that is intended to identify problems. Numerous ways 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. Concerns may be identified through:

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff.
- Revalidation.
- Monitoring of data relating to clinical 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.

5.2 Procedures for Dealing with Concerns

5.2.1 When a concern arises, relating to a particular doctor or dentist, the following procedures (which are summarised in the Process Pathway flow chart at the end of this section) will be followed: These procedures will allow for informal resolution of less serious problems.

Stage 1: Protecting the Public

5.2.2 The matter will be brought to the attention of the appropriate Clinical Director (CD), or their nominated deputy, at the earliest possible opportunity. (Should the matter relate to the conduct or performance of a CD, then the Medical Director must be informed.) The CD will then inform the Medical Director of the nature of the concern: the Medical Director must also register All serious concerns with the Chief Executive.

NB: The duty to protect patients is paramount. When a serious concern is 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. **Section 2** of this Policy sets out the procedures for this action.

Stage 2: Case Manager and Designated Board Member

5.2.3 On behalf of the Chief Executive, the Medical Director or nominated representative, in consultation with the HR Director or nominated representative, will appoint a senior clinician to act as '**Case Manager**'. This senior clinician will be appropriately experienced or trained to enable him/her to carry out this role when required. The Medical Director, or appointed representative, will act as Case Manager in all cases involving consultants. The Trust Chairman must designate a non-executive director as the '**Designated Board Member**'. The latter is charged with an overseeing role, which has the following aims:

- to ensure the concern is dealt with quickly and appropriately by the Case Manager, and that a proper audit route is established to initiate and track progress of the investigation, its costs and resulting action;

- to ensure the practitioner is kept well informed of the progress in dealing with the concern;

- where a restriction of duties, or exclusion is deemed appropriate, to ensure the practitioner is aware of their obligation to remain available for work during their normal contracted hours;

- to make arrangements to ensure that if subject to restriction/exclusion the practitioner is able to keep in contact with colleagues on professional developments, and take part in CPD and clinical audit activities, with the same level of support accorded to other practitioners;

- to appoint a mentor to provide support and ensure regular contact is maintained between the practitioner and the Trust, throughout the duration of the restriction/exclusion (assuming the practitioner is in agreement).

- To hear representations from the practitioner about the investigation or their restriction/exclusion.

5.2.4 The overriding aim is to ensure the practitioner does not feel in any way 'abandoned', unsupported, or devalued by the Trust during what is likely to be a period of uncertainty and personal anxiety. The role of the Designated Board Member is detailed in the Management Instructions and Guidelines, at **Appendix 1**.

Stage 3 Identifying if there is a problem

5.2.5 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 decision will be taken in consultation with the HR Director, the Medical Director or their appointed nominees and, where appropriate, the NCAS. (For example, in cases where clinical issues are involved or there are concerns about the individual's health. It may be less or not appropriate to involve the NCAS where the concern is one of alleged misconduct that has no clinical element. See appendix 1 for further guidance. In any case, the first approach to the NCAS should be made via the Medical Director or their appointed nominee)) Where there are concerns about a doctor or dentist in training, the Postgraduate Dean (via the Director of Medical Education) will be informed as soon as possible.

5.2.6 The Case Manager will explore the potential problem (with the NCAS where appropriate) to consider different ways of addressing it themselves. In so doing, the Case Manager should bear in mind the possibility that the problem may have as much or more to do with work systems than the practitioner's performance, or it may be a wider problem needing the involvement of an outside body (other than the NCAS. For instance, the National Patient Safety Agency (NPSA) in cases of possible systems or organisational failures (the NCAS is a division of the NPSA)

5.2.7 The role of the NCAS, and the responsibility of the Trust and individual practitioners towards the NCAS, are detailed in the Management Instructions and Guidelines, at **Appendix 1**.

5.2.8 Having discussed the case with the NCAS or other agency* if/as appropriate, the Case Manager must decide whether:

- there is no case to answer; or
- the issue is one that should be resolved through an informal approach; or
- the issue is such that a formal investigation is needed, which may lead to Disciplinary or Capability proceedings

The decision will be taken following consultation with the Medical Director and HR Director, or their nominated representatives, and take into account any advice received from the NCAS. (Where an informal route is chosen the NCAS may still be involved until the problem is resolved.) *The Case Manager may seek advice from or consult with other agencies or individuals in confidence in order to reach their decision.

5.2.9 Where the issue is such that the Case Manager determines it may lead to either Disciplinary or Capability proceedings, the Medical Director will, after discussion with the Director of Human resources or his nominated representative, appoint an appropriately experienced or trained person as '**Case Investigator'**. Once a Case Investigator has been appointed, the practitioner will be notified that a formal investigation process has been initiated. The seniority of the Case Investigator will differ, depending on the grade of practitioner involved in the allegation. The Trust will ensure that an appropriate number of suitable case investigators are trained or have the necessary experience to fulfill this role.

5.2.10 The Case Investigator is responsible for leading the investigation into the concerns about the practitioner, establishing the facts, and reporting the findings. The role of the Case Investigator is detailed in the Management Instructions and Guidelines, at **Appendix 1**.

Stage 4 Investigation

5.2.11 As soon as the decision has been taken to commission an investigation, the Case Manager will inform the practitioner, in writing, of the name of the Case Investigator, and of the specific concerns/allegations that have been raised against them (this information will be as comprehensive as possible, in terms of incidents, dates, persons involved, etc.).

The practitioner will also be given the opportunity, as early as is reasonably practicable, to see any correspondence relating to the case, together with a list of the individuals the Case Investigator intends to interview The practitioner will be able to add to this list if individuals they consider to be important witnesses are not scheduled to be interviewed. The practitioner will be required to co-operate fully and respond quickly to the Case Manager and Case Investigator in order that the investigation can be carried out in a timely and thorough manner.

NB 1: The practitioner will be afforded the opportunity to put their view of events to the Case Investigator and informed of their right, at any stage of this process (or subsequent disciplinary action) to be accompanied in any interview or hearing by a fellow employee of the Trust, an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation, who may be legally qualified, but they will not be acting in a legal capacity.

NB 2: Where a question of clinical judgment is raised during the investigation process the case investigator must formally involve a senior member of the medical staff to assist the enquiry, nominated for this purpose by the Medical Director.

5.2.12 The Case Investigator should wherever possible complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 days. The Case Manager will give the practitioner the opportunity to comment in writing on the factual content of the report. 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 particularly complex cases or due to annual leave, the deadline for comments from the practitioner will be extended. In every case any extended deadline will be made clear by the Case Manager when the request for comment is made. The practitioner may request an extension to the timescale for response, it will be for the Case Manager to agree or otherwise any such requests.

The Case Manager will review the report and, through further consultation with the Medical Director and HR Director (and the NCAS if appropriate), determine whether or not there is a case to answer, and what action should be taken. The Case Manager may seek advice from or consult with other agencies or individuals in confidence in order to reach their decision.
Where it is determined that there is a case to answer, the Case Manager, with appropriate consultation, will consider whether restrictions on practice or exclusion from work should be considered, (see procedures at **Section 2**), notwithstanding that this action may already have been taken. NB In all cases where restriction or exclusion are contemplated at any stage, the NCAS must be involved at the earliest opportunity.

Stage 5: Outcome of investigation

5.2.13 The practitioner will be informed of the outcome of the investigation, namely:

- the issue is one of **Misconduct** (e.g. bullying; harassment; assault; theft; fraud; negligence; conduct that contravenes the standard of professional behaviour required by the individual's regulatory body: willful, careless, inappropriate or unethical behaviour likely to compromise patient care or disrupt the efficient running of the service; failure to fulfill contractual obligations; failure or refusal to comply with the reasonable requirements or standards of the Trust; non-attendance at work; the commission of criminal offences outside the place of work etc; which may amount to Misconduct or gross Misconduct). Such issues will be handled under the **Trust Disciplinary Policy.** (See policy for further examples of misconduct) The practitioner will also be advised whether the alleged offence amounts to gross Misconduct, which if proven may lead to summary dismissal;

and/or

- there are problems that demonstrate a clear failure by the practitioner to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are considered to be issues of **Capability**. Examples of concerns relating to Capability include the following (this list is an illustration of issues that would be considered capability related, it is not intended to be exhaustive):

    - 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;
    - inappropriate delegation of clinical responsibility;
    - inadequate supervision of delegated clinical tasks;

- ineffective clinical team working skills.

(Wherever possible the Trust will seek to resolve the concerns through on going assessment and support. The NCAS has a key role in providing expert advice and support to facilitate the remediation of a doctor or dentist and will consequently always be consulted in such cases. Once NCAS has advised on the case, or if the practitioner refuses to be referred, the case manager must determine whether to refer the case for hearing by a Capability Panel.)

and/or

- there are concerns about the practitioner's performance that should be further considered by a **Capability Panel**;

and/or

- there are concerns about the practitioner's health that should be considered by the Trust's occupational health service (see procedures at **Section 5**);

and/or

- there are serious concerns that should be referred to the GMC or GDC, albeit that the Case Manager may have considered referral to be necessary at an earlier stage of the process;

or

- the matter can be dealt with informally

or

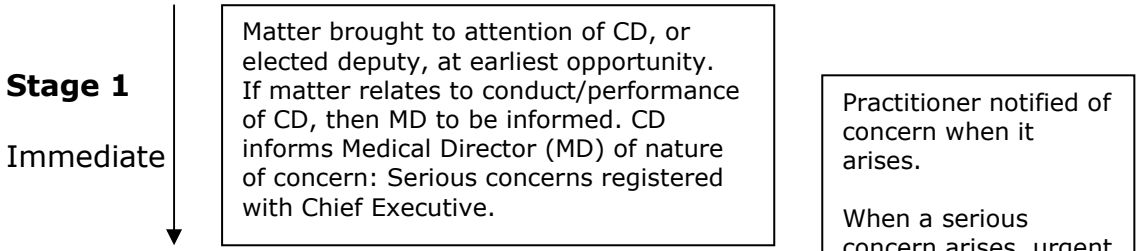
- no further action is needed.

NB: Inevitably, some cases will involve both Misconduct and Capability issues: These cases are more likely to be complex and difficult to manage. Therefore, where a case covers more than one category of problem, a decision will have to be taken

as to whether the case should be combined and considered under a Capability hearing, or whether to pursue a Misconduct issue and a Capability issue separately. In these difficult cases, the Case Manager, following consultation with the Medical Director, Director of Human Resources, NCAS and the Trust's own employment law advisers, will recommend the most appropriate course of action.

The above procedures are summarised in the Process Pathway, overleaf:

5.3 Procedure when a Concern arises – Process Pathway



Practitioner notified of concern when it arises.

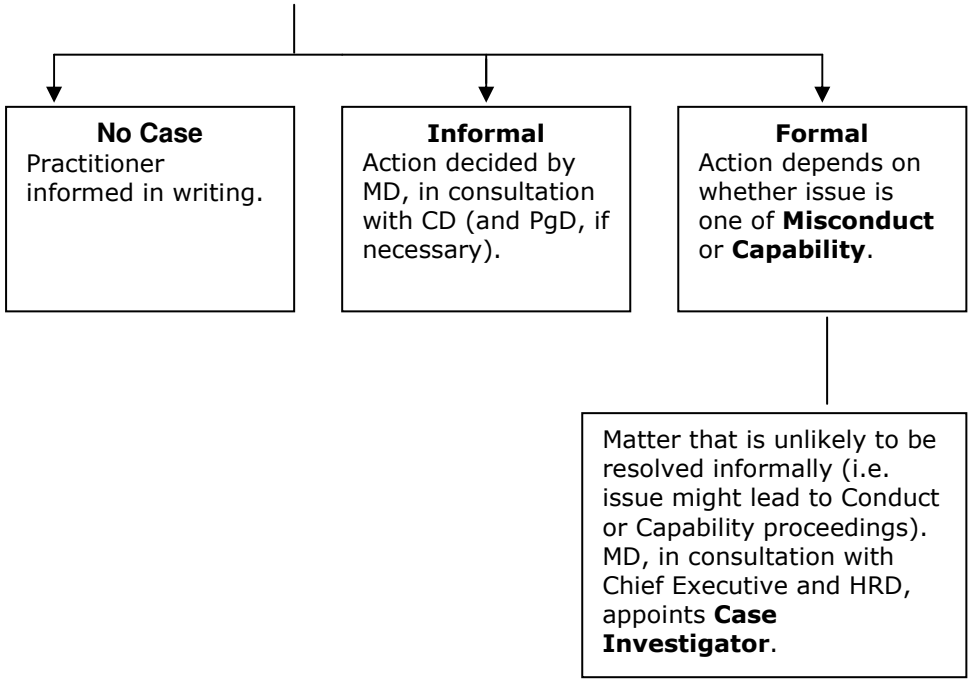
When a serious concern arises, urgent consideration will be given to temporary restriction of practice, or exclusion from workplace (see **Section 2**).

Designated Board Member to keep practitioner informed of progress and, where exclusion occurs, to offer mentoring/support

Religion | Age

Stage 2

10 working days



Stage 3

Continued overleaf:

Stages 4 and 5

30 working days

Case Manager informs practitioner of name of Case Investigator and of specific concerns/allegations raised against them. Practitioner may see any relating correspondence and list of intended interviewees. Case Investigator completes investigation and submits report to Case Manager. Case Manager reviews report and further consults with MD, HRD and if appropriate NCAS. Following consultation, Case Manager informs practitioner of outcome of the investigation, and of any further action to be taken, namely:

- The issue is one of Misconduct, that should be handled under the Trust's **Disciplinary Procedures** (see **Section 1**); and/or
- Restrictions on practice/exclusion from work should apply (see **Section 2**), notwithstanding that such action may already have been taken; and/or
- There are intractable problems or performance issues that should be considered by a **Capability Panel** (see **Section 3**); and/or
- Performance issues should be further explored by NCAS; and/or
- There are concerns about the practitioner's health that should be referred to the Trust's Occupational Health Service (see **Section 5**); and/or
- There are serious concerns that should be referred to the GMC/GDC; or
- The matter can be dealt with informally or
- No further action is needed.

Cases involving issues of both **Misconduct and Capability** Case Manager, in consultation with MD, DHR, NCAS and Trust's employment law advisers, recommends best course of action. (E.g. both considered by a **Capability Panel**, or heard separately)

Designated Board Member to keep practitioner informed of progress.

Practitioner has right, at any stage of process, to be accompanied in any interview.

Practitioner has right to view investigation report and comment upon accuracy.

Sexual Orientation | Religion | Age

5.4 Action when possible Criminal Acts are identified

5.4.1 Where an initial concern or investigation identifies a suspected criminal action in the UK or abroad, this will be reported to the police. In cases of fraud, the Counter Fraud and Security Management Service (CSFMS) will be contacted. The Trust will consult the police and/or the CFSMS to establish whether and to what extent the Trust's own actions including any investigation should be modified so as not to prejudice the outcome of any action proposed by the police or CFSMS. **NB** The fact that the police, CPS or CFSMS chose not to pursue a particular issue or fail to secure a prosecution will not necessarily indicate that the Trust will make the same decisions in respect of the case.

5.5 Cases where Criminal Charges are brought, not connected with a known concern (or employment with the Trust)

5.5.1 There are some criminal offences that, if proven, could render a doctor or dentist potentially unsuitable for continued employment, even where the offence was not raised as a concern in relation to this policy, or indeed connected with their employment in any way. In all cases, the Trust, having considered the facts, will need to determine whether the practitioner poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and/or exclusion. The Trust will need to give serious consideration to whether the practitioner is able to 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 a criminal trial, the practitioner 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 fully explain to the practitioner the reasons for taking any such action.

5.6 Dropping of Charges or no Court Conviction

5.6.1 When the Trust has refrained from taking action pending the outcome of a court case, if the practitioner is acquitted but it is considered there is enough evidence to suggest a potential danger to patients, then the Trust has a public duty to take action to eliminate this risk. Similarly, where there are insufficient grounds for bringing charges, or the court case is withdrawn, there may be grounds for local procedures to be begun or restarted where the allegations would, if proved, constitute misconduct within the terms of this policy. (see also 5.4 above)

5.7 Confidentiality

5.7.1 The Trust will maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Trust will only confirm that an investigation or disciplinary hearing is underway. Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and proportionate to the seriousness of the matter under investigation.

SECTION 2

6.0 RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK

6.1 Managing the Risk to Patients or other Members of Staff

6.1.2 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 or obtain undertakings) or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the Postgraduate Dean will be involved as soon as possible.

6.1.3 Under this Policy, the following principles will always apply:

- Exclusion of clinical staff from the workplace is a temporary expedient whilst action to resolve a problem is being considered.
- Exclusion is viewed as a precautionary measure and not a disciplinary sanction.
- Exclusion from work will be applied only in the most exceptional circumstances.

6.1.4 The Trust will take every measure to ensure 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 of the concerns and on the

need to protect patients, the practitioner concerned and/or their colleagues. No practitioner will be excluded from work other than through this procedure. Informal exclusions of whatever type will not be used.

6.1.5 The purpose of exclusion is to:

- protect the interests of patients, the practitioner, or other staff; and/or
- assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

6.2 Restriction of Practice

6.2.1 The Trust will always consider whether risks may be managed by restricting the practice of the individual concerned, rather than resorting to exclusion. Where this is appropriate, the degree to which practice is restricted will be determined by the particular circumstances of each case. Ways in which risks may be managed by restricting practice might 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, this might include some formal retraining or re-skilling);
- Sick leave for the investigation of specific health problems.

6.2.2 In the rare event that **immediate restriction** is necessary, this must be sanctioned by the Medical Director, or if unavailable, another Executive Director. Where, following formal investigation, a restriction of practice is indicated the Case Manager will determine the nature of this restriction. (The Case Investigator will explore and report on the circumstances that suggest the need to restrict the practice of the practitioner. The Case Investigator will also provide factual information

to assist the Case Manager in reviewing the need for restriction and in making progress reports to the Chief Executive and Designated Board Member.) The practitioner will always be notified, in writing, of the degree to which their practice is to be restricted, the means by which the restriction will be managed, and the reasons for this action being taken. All restrictions of practice will be determined by the case manger and registered with the Medical Director, and will be subject to the same review procedure that is associated with the exclusion process (see below).

6.3 The Exclusion Process

6.3.1 Key features of Exclusion from Work are as follows:

- An initial "immediate exclusion'' of no more than two weeks if warranted;
- Notification of the NCAS before formal exclusion; (not 'immediate exclusion')
- Formal exclusion (if necessary) for periods up to four weeks;
- Advice on the case management plan from the NCAS;
- Appointment of a Board member to monitor the exclusion and subsequent action;
- Referral to NCAS for formal assessment, if part of case management plan;
- Active review to decide renewal or cessation of exclusion;
- A right to return to work if review not carried out;
- Performance reporting on the management of the case;
- Programme for return to work if not referred to disciplinary procedures or performance assessment.

6.3.2 Where exclusion, rather than restricting practice, is deemed an essential course of action, the Trust cannot require the exclusion of 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. Under exclusion procedures, key officers and the Board have responsibilities for ensuring the process is carried out quickly and fairly, kept under review, and that the total period of exclusion is not unnecessarily prolonged. The practitioner likewise has a duty to co-operate with the case manager and case investigator to enable them to fulfill their responsibilities and to ensure any exclusion (or restriction of practice) is for as short a period as possible.

Persons involved

6.3.3 The **Chief Executive** has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. Therefore, before a decision is taken to **formally exclude** a practitioner, the reasons for exclusion will be discussed fully with the **Chief Executive**, **Medical Director and HR Director** or their nominated representatives, the NCAS and other interested parties (such as the police where there are serious criminal allegations, or the Counter Fraud and Security Management Service). In the rare cases where **immediate exclusion** is required (see below), the Medical Director and HR Director, or their nominated representatives, must discuss the case at the earliest opportunity following exclusion, by means of a case conference.

6.3.4 For immediate exclusions, the authority to sanction the exclusion of a practitioner is vested in the Chief Executive, or if unavailable the Medical Director, or other Executive Director only.

6.3.5 Where the decision to exclude a practitioner arises from an investigatory process, the **Investigating Officer** will provide factual information to assist the **Case Manager** in reviewing the need for exclusion and in making reports on progress to the Chief Executive and **Designated Board Member**.

6.3.6 The Designated Board Member (see Management Instructions and Guidance, at **Appendix 2**) will ensure that time frames for investigation and/or exclusion are adhered to.

Immediate Exclusion

6.3.7 In exceptional circumstances, an **immediate exclusion** time limited to no more than two weeks may be necessary, for the following reasons:

- to protect the interests of patients, the practitioner or other staff;
- following a critical incident when serious allegations have been made;
- where there has been a serious breakdown in relationships between a colleague and the rest of the team;
- where the presence of the practitioner is likely to hinder an investigation.

6.3.8 Such an exclusion will allow a more measured and dispassionate consideration to be undertaken, following an incident. This 'breathing space' will be used to carry out a preliminary situation analysis, to contact the NCAS for advice (which should be done at the earliest opportunity following exclusion) and to convene a case conference. The person sanctioning the immediate exclusion (i.e. **Chief Executive, Medical Director, Executive Director,)** must ensure the practitioner is informed:

- in broad terms, why there is a need to make an immediate exclusion (there may be no formal allegation at this stage);
- that they will be informed, at the earliest opportunity, when they will be called back to attend a further meeting: This will be at the earliest opportunity, but in any case, no longer than one working week following immediate exclusion, at which time the practitioner will be notified of the precise nature of the allegation, including specific incidents, dates, persons involved, etc.
- that immediate exclusion in no way amounts to disciplinary action.

Formal Exclusion

6.3.9 No practitioner will be excluded from work, other than by way of an immediate exclusion, except through a formal procedure. No 'informal' exclusions, of whatever type, will be tolerated by the Trust. A **formal exclusion** may only take place after the Case Manager has first considered, at a case conference, involving the Medical Director, HR Director and Designated Board Member, whether there is a reasonable and proper case to exclude.

6.3.10 The NCAS must always be consulted by the Case Manager, where the intention is to invoke formal exclusion, following which the appropriate CD or Medical Director will be responsible for informing the practitioner of the exclusion. This action will be taken via a formal meeting, at which:

- the practitioner may be accompanied by a companion (see 5.2.5, above);
- the CD or Medical Director will have an HR colleague present who may be the HR Director, as an independent witness;
- the precise nature of the allegations or areas of concern will be conveyed to the practitioner;
- the practitioner will be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case;
- the practitioner will be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction).

6.3.11 The formal exclusion will be confirmed in writing as soon as is reasonably practicable, with a standard of within two working days. This confirmation will state the effective date and time; duration (up to 4 weeks); the content of the allegations; the terms of the exclusion (e.g. total exclusion from the premises - see **Management Instructions and Guidance, at Appendix 2** - or exclusion from a particular place of work); the need to remain available for work, and that a full investigation (or what other action) will follow. The practitioner will 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.

6.3.12 In cases where disciplinary or capability procedures are being followed, and where a return to work is considered inappropriate, exclusion may be extended for four-week renewable periods. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion will be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, as soon as the original reasons for exclusion no longer apply.

6.3.13 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 the NCAS, who will advise whether the case is being handled in the most effective way and suggest possible ways forward. However, even during this prolonged period, the principle of four-week 'renewability' will be adhered to.

6.3.14 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.

6.4 Keeping Exclusions under Review

Informing the Trust Board

6.4.1 The Trust Board will be informed of an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed, and will therefore require a summary report of the progress of each case at each meeting of the Trust 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. The Case Manager is responsible for providing such reports to the Board, via the HR Director.

Regular review

6.4.2 The Case Manager will review the exclusion before the end of each exclusion period (which may be up to four weeks each), and report the outcome to the Chief Executive and Trust Board. This report is advisory and it is for the Case Manager to decide on the next steps, as appropriate. The exclusion should be lifted, and the practitioner allowed to return to work, with or without conditions placed upon their employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The Trust must take review action before the end of each four-week period: Otherwise, on expiry of the four-week period, the exclusion will lapse and the practitioner will be entitled to return to work. Following three successive four-week exclusion periods, the case must be referred formally to the NCAS in order that they may review how the case is being handled, and whether the period of exclusion remains appropriate in their view.

6.4.3 The review activities that will be undertaken at different stages of exclusion are as follows (see overleaf):

Stage	Activity
First and Second Reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the situation: ▪ The Case Manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time.

	▪ Case Manager submits advisory report of outcome to the HR Director and Medical Director. ▪ Each renewal is a formal matter and must be documented as such: The practitioner must be sent written notification on each occasion. The HR Director or Designated HR Manager is responsible for ensuring these actions are completed.
Third Review	If the practitioner has been excluded for three periods: ▪ The Case Manager submits a situation report to the Chief Executive, outlining: - the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and, if the investigation has not been completed, - a timetable for completion of the investigation. ▪ The Chief Executive must then report to the Strategic Health Authority (SHA) and the Designated Board Member (see Management Instructions and Guidelines, at **Appendix 2**).

	▪ The case must formally be referred to the NCAS, explaining: - why continued exclusion is appropriate; - what steps are being taken to conclude the exclusion at the earliest opportunity. The NCAS will review the case and advise the Trust on the further handling of the case until it is concluded.
Stage	**Activity**
6 Months Review N.B: Normally there will be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned, and where the investigation is lengthy. The Trust and the NCAS will actively review such cases at least every 6 months.	If the exclusion has been extended over six months: ▪ The Chief Executive submits a further situation report to the SHA indicating: - the reason for continuing the exclusion; - the anticipated time scale for completing the process; - the actual and anticipated final costs of the exclusion. ▪ The SHA 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 practical advice to be offered to the Trust Board.

Review

6.4.4 Where a practitioner considers that a decision to exclude or restrict practice has been applied unfairly, or that there are other reasonable alternatives to exclusion, then the practitioner may apply to have their reasons considered and determined by the Case Manager, who must respond with their decision to the practitioner in writing within seven days, copying this correspondence to the Designated Member.

SECTION 3

7.0 PROCEDURES FOR DEALING WITH ISSUES OF CAPABILITY

7.1 Wherever possible, the Trust will aim to resolve issues of Capability (including clinical competence and health) through ongoing assessment and support, which might include counselling and/or re-training. The NCAS has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and will always be consulted by the Case Manager. Any concerns about Capability relating to a doctor or dentist in a recognised training grade will be considered initially as a training issue and dealt with via the Director of Medical Education, with close involvement of the Postgraduate Dean from the outset.

7.2 Capability may be affected by ill health. Procedures for handling concerns about a practitioner's health are detailed in **Section 5** of this policy.

7.3 The Trust will ensure that investigations and Capability procedures are conducted in a way that does not unfairly discriminate on the grounds of race, gender, disability, age or indeed on other grounds. Case Managers and Investigators will receive appropriate and effective training in the operation of Capability procedures. Those undertaking investigations or sitting on Capability or appeals panels will have received formal equal opportunities training before undertaking such duties.

Capability Procedure

Further to the decision taken at Stage 5 of 'Procedure When a Concern Arises':

7.4 The Pre-hearing Process

7.4.1 When the Case Investigator has submitted a report of the investigation, the Case Manager will give the practitioner the opportunity to comment in writing on the factual content of the report. 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 particularly complex cases or due to annual leave, the deadline for comments from the practitioner will be extended. . In every case any extended deadline will be made clear by the Case Manager when the request for comment is made. The practitioner may request an extension to the timescale for response, it will be for the Case Manager to agree or otherwise any such requests.

7.4.2 The Case Manager will 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 the NCAS. Notwithstanding that such actions may already have been taken, the Case Manager will consider urgently:

- whether action under **Section 2** of this policy is necessary to exclude the practitioner; or

- whether temporary restrictions should be placed on the practitioner's clinical duties.

7.4.3 The Case Manager will again consider, with the Medical Director and HR Director, whether the issues of Capability can be resolved through local action (such as re-training, counselling, performance management). If this action is not practicable for any reason, the matter must be referred to the NCAS 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. The NCAS will assist the Trust to draw up an action plan designed to enable the practitioner to remedy any lack of Capability that has been identified during the assessment. The Trust will facilitate the action plan (which has to be jointly agreed by the Trust and the practitioner before it is actioned).

7.4.4 There may be occasion when a case has been considered by the NCAS, 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 issue should be considered by a Capability Panel (CaP), in which case a hearing will be necessary.

If the practitioner does not agree to the case being referred to the NCAS, in the first instance, again a panel hearing will normally be necessary.

7.4.5 The following procedure will be followed prior to a Capability hearing:

- The Case Manager will 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 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.

- Wherever practicable, 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 Trust will consider whether a new date should be set for the hearing.

- Should either party request a postponement to the hearing, the Case Manager will be 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 normally less than 30 working days), to proceed with the hearing in the practitioner's absence: The Trust will always act reasonably in deciding to do so.

- Should the practitioner's ill health prevent the hearing taking place, the Trust's usual sickness absence procedures will be invoked (in accordance with the Trust's Attendance Policy). 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 a hearing. Where the practitioner's illness exceeds 4 weeks, they will 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 that it may have for the Capability process.

- If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill health, the practitioner should have the opportunity to submit written submissions and/or have a representative attend in their absence.

- Witnesses who have made written statements at the investigation stage may, but will not necessarily, be required to attend the Capability hearing**.** Following representations from either side contesting a witness statement that is to be relied upon in the hearing, the Chairman may 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 required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

7.5 The Hearing Framework

7.5.1 An Executive Director of the Trust will normally chair the CaP. In addition to the Chair, the Panel will comprise a total of three people: normally two members of the Trust Board, or senior members of staff appointed by the Board for the purpose of the hearing. The third member will be a medical or dental practitioner not employed by the Trust. The Panel will also be advised by a senior HR representative, nominated by the HR Director (whose main role will be to ensure that due process is followed, throughout) and by a senior clinician from the same speciality as the practitioner concerned, but from another NHS employer. As far as is reasonably possible or practicable, no member of the Panel or adviser to the Panel should have been previously involved in the investigation. The Trust will discuss the selection of the medical or dental practitioners with the chairs of the LNC and Medical Staff Committee.

NB: 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 should be asked to provide advice.

7.5.2 Whilst it is for the Trust to decide on 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 then 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 will provide the practitioner with the reasons for reaching its decision, in writing, before the hearing takes place.

7.6 Representation at Capability Hearings

7.6.1 The hearing is not a court of law. Whilst the practitioner will be given every reasonable opportunity to present their case, the hearing will not be conducted in a legalistic or excessively formal manner. The protocol to be followed during the hearing is detailed at paragraph 8.7 of this Section.

7.6.2 The practitioner will be informed of their right, to be accompanied in the hearing, by a companion who may be another employee of the Trust, an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation. Such a representative may be legally qualified but they will not, however, 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.

7.7 Decisions

7.7.1 The Panel will have the power to make a range of decisions including the following:

- No action required.
- 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 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 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 record for 1 year).
- Termination of contract.

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 Trust that the Panel wishes to comment upon.

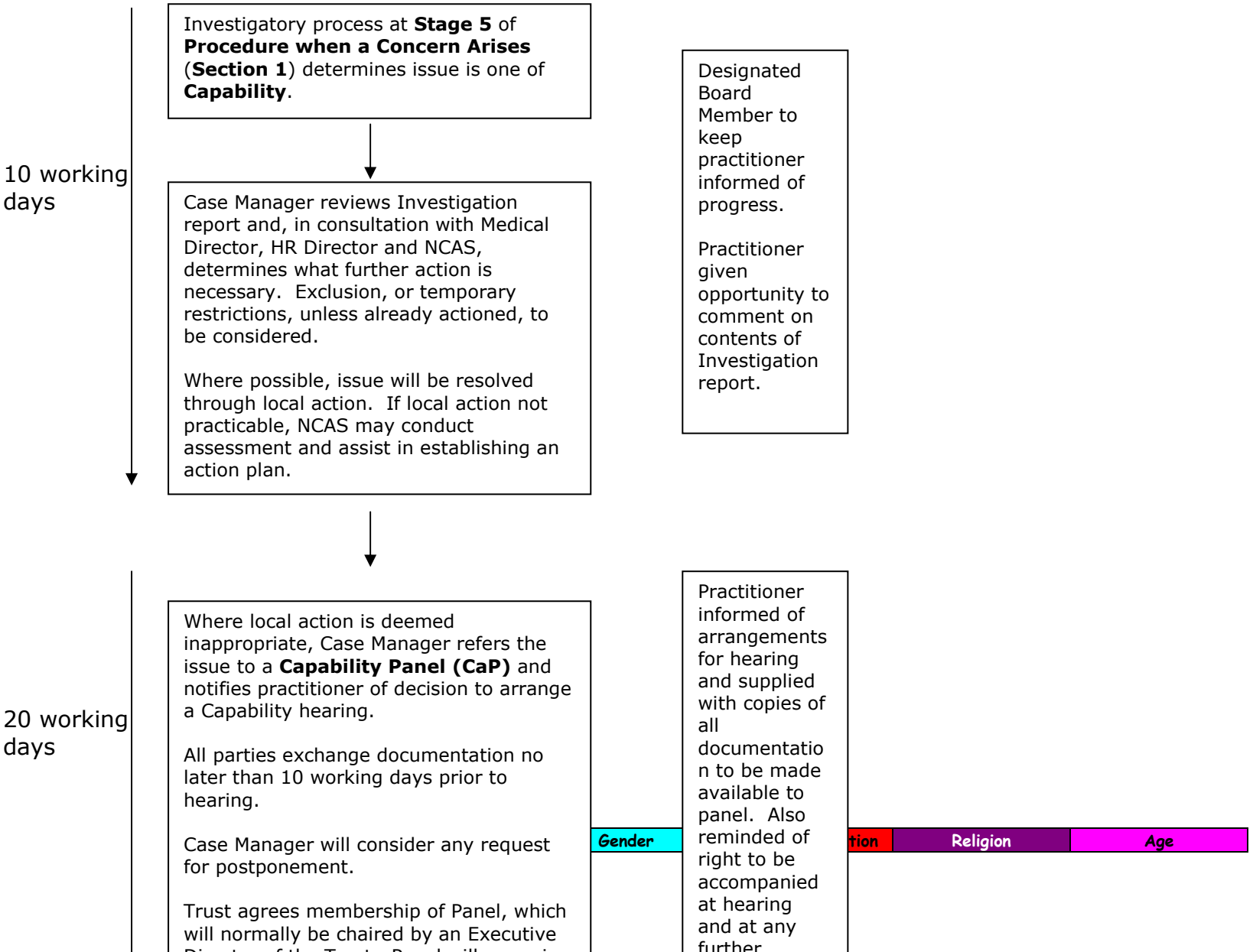
7.7.2 A record of agreements and written warnings will be retained in the practitioner's personnel file, but will be removed following the specified period.

7.7.3 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 potential 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.

7.7.4 The decision will be confirmed in writing to the practitioner. This notification will 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. The practitioner has the right to appeal against the decision, in accordance with the Appeals Procedure at **Section 4** of this policy.

The above procedures are summarised in the Process Pathway, overleaf:

7.8 Capability - Process Pathway



Gender | tion | Religion | Age

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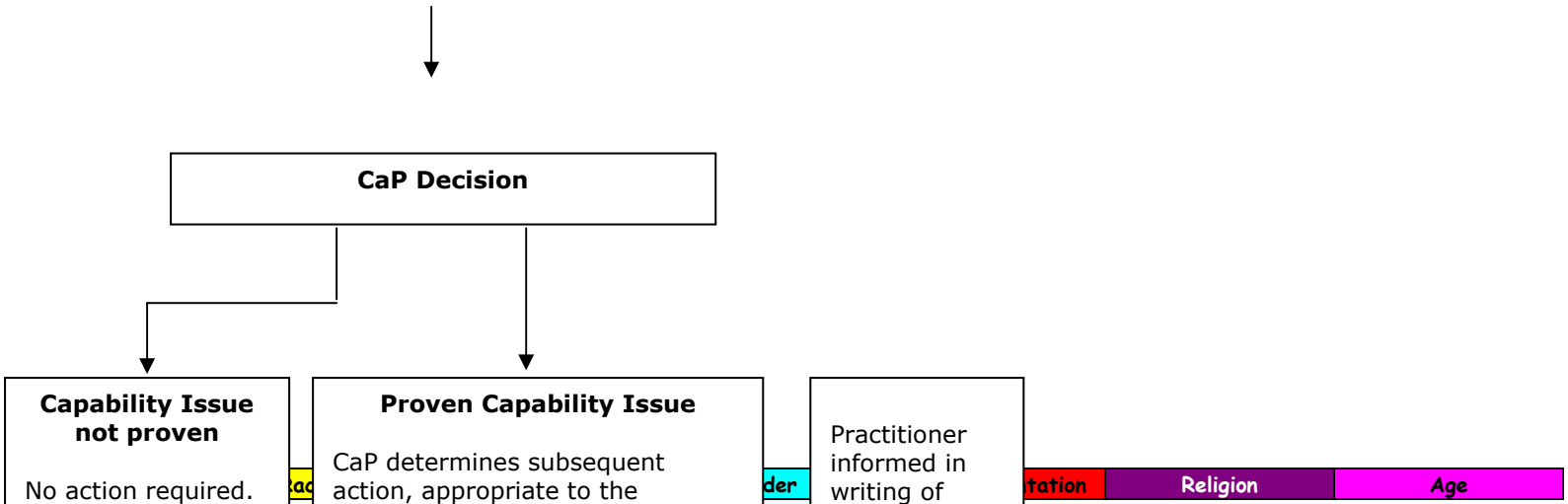


ace	Disability	Gender	Sexual Orientation	Religion	Age

Race	Disability	Gender	Sexual Orientation	Religion	Age

7.9 Protocol to be followed for Capability Hearings

7.9.1 As soon as it has been determined that a Capability Panel (CaP) needs to be formed, the practitioner will be provided with written confirmation of this decision, confirmation of the allegations made against him and details of his rights to be accompanied. As soon as possible, thereafter, and at least 20 working days before the hearing, the practitioner will also be informed of the constitution of the Panel, provided with copies of the Case Manager's report and any associated investigation documentation and any documentation and/or evidence that will be made available to the Panel, including witness statements. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification (The reasons for the objection must be given in writing). 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 (normally not in excess of 30 days) while this matter is resolved. The trust will provide the practitioner with the reasons for reaching for reaching its decision in writing before the hearing takes place.

7.9.2 The Panel's appointed HR representative will act as the Panel Co-ordinator, who is responsible for the administrative aspects relating to the hearing. The Panel Co-ordinator will write to the practitioner to confirm the date and venue set for the hearing, and to request that any written evidence the practitioner wishes to present at the hearing, including witness statements, are submitted at least ten working days before that date. The practitioner may invite witnesses to attend the

hearing, if they so wish, in which case they must arrange for their witnesses to attend if they are agreeable. The Panel Co-ordinator will confirm that everyone involved with the hearing is available to attend, and inform all parties of any necessary changes to the administrative arrangements.

7.9.3 Once the Panel, the practitioner and their representative are assembled, the Chair of the Panel is responsible for managing the hearing, and ensuring the following protocol is followed:

- Chair introduces those present, summarises why the hearing has been convened, and explains how the hearing will be conducted.
- Chair explains that the Panel Co-ordinator will be responsible for ensuring a written record of the proceedings is made.
- Chair calls the Case Manager to present the case against the practitioner. Case Manager will provide documentary evidence and call witnesses, as appropriate.
- Practitioner and their representative are given the opportunity to ask any questions of the Case Manager and witnesses.
- Panel members are invited to ask questions of the Case Manager and witnesses.
- Practitioner and/or their representative are invited to present their case, and to provide any documentary evidence and call witnesses, as appropriate.
- Case Manager is given the opportunity to ask questions of the practitioner, their representative, and witnesses.
- Panel members are invited to ask questions of the practitioner, their representative and witnesses.
- Chair may ask questions of either party, and ask for points of clarification.
- Case Manager is asked to sum up.
- Practitioner, or their representative, is asked to sum up.

- Both parties are asked to leave the hearing, whilst the Panel members confer in private, but to be available to return should the Panel need clarify any points of uncertainty.

- Panel makes its decision and both parties are recalled, and informed by the Chair of that decision.

- Alternatively, the panel determines further deliberation is required, in which case both parties are recalled and informed accordingly, and an estimate of when the decision will be made given (normally within 5 days see para 7.7.3 above)

- Where the Panel has determined that there is a proven Capability issue, the practitioner is informed of the disciplinary/administrative action to be taken against them. The practitioner is informed of their right to appeal against the Panel's decision.

7.9.4 Witnesses will be admitted only to give their evidence and answer any questions, and will then retire. The procedure for dealing with any witnesses attending the hearing will be the same and reflect the following:

- the witness to confirm any written statement and give any supplementary evidence;

- the side calling the witness may question the witness;

- the other side may then question the witness;

- the Panel may question the witness;

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

7.9.5 Following the hearing the Panel Co-ordinator will ensure the practitioner receives written confirmation of the outcome (see para 7.7.4 above), and of any disciplinary/ administrative action to be taken against them. The practitioner will also be reminded of the Appeals Procedure at **Section 4**, below.

ace	Disability	Gender	Sexual Orientation	Religion	Age

Race	Disability	Gender	Sexual Orientation	Religion	Age

SECTION 4

8.0 APPEALS PROCEDURE (Following Capability Panel Hearings)

8.1 Purpose

8.1.1 The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a Capability Panel decision to have an opportunity for the case to be reviewed. (**NB** this appeal procedure does not apply to cases being conducted under the Trust's disciplinary procedure, which has its own appeals procedure) The appeal panel will need to establish whether the Trust's procedures have been adhered to and that, in arriving at their decision, the Panel acted fairly and reasonably, based upon:

- 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.

The Panel may also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The Panel, however, will not re-hear the entire case.

8.1.2 A dismissed practitioner will, in all cases, be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

8.1.3 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 will have the power to instruct a new Capability hearing.

8.1.4 Where the appeal is against dismissal, the practitioner will not be paid during the period of appeal, from the date of termination of employment. Should the appeal be upheld, the practitioner should normally be reinstated and will receive backdated pay, to the date of termination of employment. Where the decision is to re-hear the case, the practitioner will also normally be reinstated, subject to any conditions or restrictions in place at the time of the original hearing, and will receive backdated pay, to the date of termination of employment.

8.2 The Appeal Panel

8.2.1 The appeal panel will consist of three members, who will 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. Membership will be as follows:

- an independent member (trained in legal aspects of appeals) from an approved pool (as agreed and established by the BMA, BDA and NHS Employers - see **Appendix 3**), designated Chairman;

- the Trust Chairman (or other Trust Non-Executive Director)
- a medically qualified member (or dentally qualified if appropriate), who is not employed by the Trust. (the appointment of this panel member will be discussed with the Chairs of the MSC and LNC)

All members will be suitably experienced or trained to be able to participate in an appeal hearing.

8.2.2 The Panel will call on others to provide specialist advice. This should normally include:

- a consultant from the same speciality or subspecialty as the appellant, but from another NHS employer;
- a Senior HR specialist.

It is important 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.

8.2.3 It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original hearing. Wherever practicable, the following timetable will apply:

- appeal by written statement to be submitted to the designated appeal point (the HR Director, or their nominated representative) 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.

In all cases, the timetable will be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The Case Manager is responsible for ensuring that extensions are absolutely necessary, and kept to a minimum.

8.3 Powers of the Appeal Panel

8.3.1 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. 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 will 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.

8.3.2 If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it will 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.

8.4 Conduct of Appeal Hearing

8.4.1 All parties will be in possession of all documents, including witness statements, from the previous hearing, together with any new evidence.

8.4.2 The appellant will be informed of their right, to be accompanied in the hearing, by a companion who may be another employee of the Trust, an official or lay representative of the British Medical Association (BMA), British Dental Association (BDA) or defence organisation. Such a representative may be legally qualified but they will not, however, be representing the appellant 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.

8.4.3 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 will briefly sum up. At this stage, no new information may be introduced, however the appellant (or their companion) may make a statement in mitigation.

8.4.4 The Panel, after receiving the views of both parties, will consider and make its decision in private.

8.5 Decision

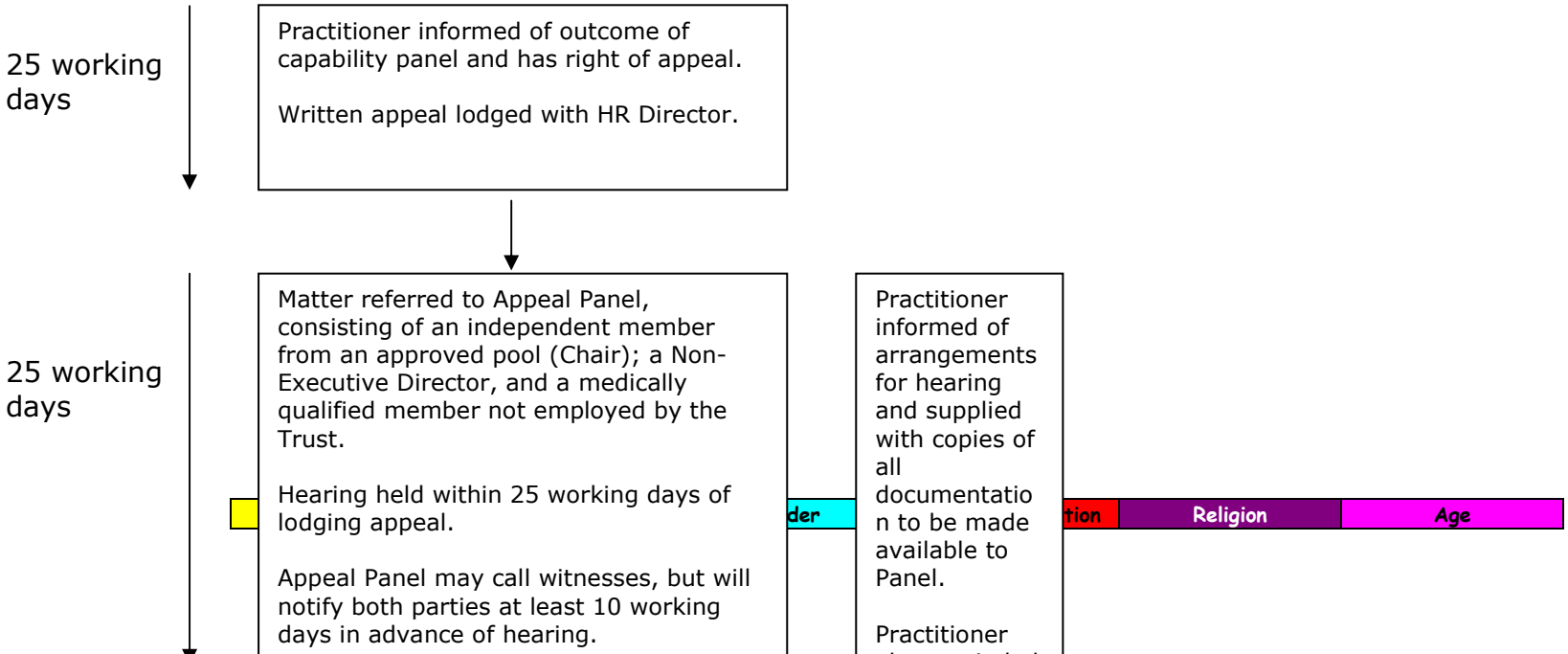
8.5.1 The decision of the appeal panel will be made in writing to the appellant and copied to the Case Manager, such that it is received within 5 working days of the conclusion of the hearing. The decision of the appeal panel is final and binding. There will be no correspondence on the decision of the Panel, except and unless clarification is required on what has been decided (but not on the merits of the case), in which case it must be sought in writing from the Chairman of the appeal panel.

8.6 Action following Hearing

8.6.1 Records will 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 will remain confidential and retained in accordance with the Data Protection Act 1998. These records will 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.

The above procedure is summarised in the Process Pathway, overleaf:

8.7 Appeals Procedure following a Capability Panel– Process Pathway



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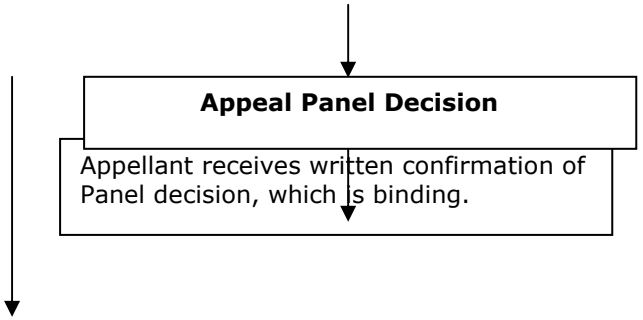
5 working days



SECTION 5

9.0 Procedures for handling concerns relating to a Practitioner's Health

9.1 Introduction

9.1.1 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 workplace factors such as stress. The underlying 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, and kept in employment, rather than be lost from the NHS.

9.2 Retaining the Services of Individuals with Health Problems

9.2.1 Wherever possible, the Trust will attempt to continue to employ the practitioner, provided this does not place patients or colleagues at risk. This may involve one or more of the following activities:

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to maintain contact and prevent them from feeling isolated);
- removing the practitioner from certain duties;
- reassignment to a different area of work;
- arranging re-training or adjustments to the practitioner's working environment, with appropriate advice from the NCAS and/or deanery, under reasonable adjustment provision in the Disability Discrimination Act 1995.

9.2.2 At all times, the practitioner will be supported by the Trust and the Occupational Health Service (OHS), who will ensure that the practitioner is offered every available resource to be able to return to practise, where appropriate. The Trust will consider what reasonable adjustments might be made to their workplace conditions, or other arrangements. Examples of reasonable adjustment include:

- making adjustments to the premises;
- re-allocation of some duties to colleagues;
- transfer of the practitioner to an existing vacancy;
- altering the practitioner's working hours, or pattern of work;
- assignment to a different workplace;
- allowing absence for rehabilitation, assessment or treatment;
- provision of additional training or re-training;
- acquiring/modifying equipment;
- modifying procedures for testing or assessment;
- establishing mentoring arrangements.

9.2.3 In some cases, retirement due to ill health may be necessary. Ill-health retirement will be approached in a reasonable and considerate manner, in line with NHS Pensions Agency Advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures, where appropriate.

9.3 Handling Health Issues

9.3.1 Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine the precise nature of that problem. In such cases, the Case Manager will immediately refer the practitioner to the Trust's Occupational Health Physician. The NCAS will also be approached to offer advice on any situation and at any point where the Trust is concerned about a practitioner's health. Even apparently simple or early concerns will be referred, as these are easier to deal with before they escalate.

9.3.2 The Occupational Health Physician will agree a course of action with the practitioner and send their recommendations to the Medical Director. A meeting will then be convened with the HR Director, or their nominated representative, the Medical Director, or their nominated representative, or Case Manager, the practitioner and caseworker from the OHS. The purpose of this meeting will be to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings, who might be a colleague or a trade union or defence association representative. Confidentiality will be maintained by all parties, at all times.

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

9.3.4 In those cases where there is impairment of performance solely due to ill-health, disciplinary procedures will only be considered in the most exceptional of circumstances, for example if the practitioner refuses to co-operate with the Trust to resolve the underlying situation by repeatedly refusing a referral to the OHS or the NCAS. In these circumstances, the procedures for dealing with issues of Capability (see **Section 3.0**, above) will be followed.

9.3.5 There will be circumstances where a practitioner who is subject to disciplinary proceedings submits a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the practitioner 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.

ace	Disability	Gender	Sexual Orientation	Religion	Age

Race	Disability	Gender	Sexual Orientation	Religion	Age

Appendix 1:

PROCEDURE WHEN A CONCERN ARISES – MANAGEMENT INSTRUCTIONS AND GUIDANCE

1.0 Involving the NCAS

Understanding the Issue, and Investigation

1.1 At any stage of the handling of a case consideration must be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides NHS trusts and practitioners. This involves:

- Immediate telephone advice, available 24 hours.
- Advice then detailed supported local case management.
- Advice then supported local clinical performance assessment.
- Advice, then detailed NCAS clinical performance assessment.
- Support with implementation of recommendations arising from assessment.
- Understanding the issue and investigation.

1.2 The first stage of the NCAS's involvement in a case is exploratory, i.e. an opportunity for local managers to discuss the problem with an impartial outsider; to look afresh at a problem; see new ways of tackling it themselves; possibly recognise the problem as being to do with work systems rather than solely practitioner performance, or recognise a wider problem needing the involvement of an outside body other than the NCAS.

1.3 Having discussed the case with the NCAS if felt appropriate, 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 the NCAS may still be involved until the problem is resolved. This may include the NCAS undertaking a formal clinical performance assessment when the doctor, the Trust and the NCAS agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps.

1.4 Where the NCAS is asked to undertake an assessment of the practitioner's practice, the outcome of a local investigation may be made available to inform the NCAS's work.

Involvement of the NCAS following Local Investigation

1.5 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. The NCAS's processes are aimed at addressing all of these; particularly where local action has not been able to take matters forward successfully. The NCAS's methods of working therefore assume commitment by all parties to take part constructively in a referral to the NCAS. For example, its assessors will work to formal terms of reference, decided upon after input from the Case Manager and the practitioner.

1.6 The focus of the NCAS's work is therefore likely to involve performance difficulties that are serious and/or repetitive. This 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.

1.7 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. The NCAS may advise on this.

1.8 Where consideration is being given to excluding a practitioner (see **Section 2** of the Policy), whether or not their performance is under discussion with the NCAS, it is important for the NCAS to know of this at an early stage, so that alternatives to exclusion can be considered. It is particularly desirable to find an alternative when the NCAS is likely to be involved, because it is much more difficult to assess a practitioner who is excluded from practice than it is to assess one who is working.

1.9 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 the NCAS 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 the NCAS before a Capability Panel can consider the matter, unless the practitioner refuses to have his case referred. It is also advisable to involve the NCAS in all other cases, particularly those involving clinical matters.

Further guidance on NCAA processes, and how to make referrals, may be found at the NCAA website: http://www.ncas.npsa.nhs.uk/

2.0 Role of the Case Investigator

2.1 Following the decision that an issue cannot be resolved informally, and that a more formal route needs to be followed, the Medical Director or his nominated representative, in consultation with the HR Director, or his nominated representative will appoint an appropriately experienced person to act as Case Investigator. The Case Investigator is responsible for leading an investigation into the concerns/issue, establishing the facts and reporting the findings.

2.2 The Case Investigator will:

- where a question of clinical judgement is raised during the investigation process, formally involve a senior member of the medical or dental staff (unless the Case Investigator satisfies these requirements). Where the NHS body employs no other suitable senior doctor or dentist a senior doctor or dentist from another NHS body should be involved.

- 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: 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.

- ensure there are sufficient written statements collected to establish a sufficiently comprehensive case prior to a decision to convene a 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.

- ensure that a written record is kept of the investigation, its conclusions, and the outcome.

- assist the Designated Board Member in reviewing the progress of the case.

2.3 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.

2.4 The Case Investigator has wide 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 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.

2.5 The Case Investigator will endeavour to complete the investigation within 4 weeks, and submit their report to the Case Manager within 5 days of completion (see paragraph 5.2.14).

Appendix 2:

RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK - MANAGEMENT INSTRUCTIONS AND GUIDANCE

1.0 Exclusion from Premises

1.1 The practitioner will not be automatically barred from the premises upon exclusion from work. The Case Managers must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner will be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where a practitioner may be a serious potential danger to patients or other staff. In other circumstances, however, there may be no good reason to exclude the practitioner from the premises. Keeping the practitioner in the workplace will allow them 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.

2.0 Keeping in Contact and Availability for Work

2.1 As exclusion under this Policy will usually be on full pay, the practitioner must remain available for work with the Trust 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 the 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 wherever practicable, must 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). Authority not to pay rests with the HR Director.

2.3 The Case Manager should make arrangements to ensure that the practitioner is able to 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. A mentor could be appointed for this purpose, if a colleague is willing to undertake this role.

3.0 Informing other Organisations

3.1 In cases where there is concern that the practitioner may be a danger to patients, the Trust 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 the

practitioner's job plan, but where it is not, the practitioner should supply them, upon request. 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 the Trust has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

3.2 Where the Case Manager believes the practitioner is practicing in other parts of the NHS, or in the private sector, in breach or defiance of an undertaking not to do so, they should contact the professional regulatory body and the Director of Public Health or Medical Director of the Strategic Health Authority to consider the issue of an Alert Letter.

4.0 The Role of the SHA in Monitoring Exclusions

4.1 When the SHA is notified of an exclusion, it should ensure that the NCAS has also been notified. When an exclusion decision has been extended twice, the HR Director (on behalf of the Chief Executive) must inform the SHA of what action is proposed to resolve the situation. This should include dates for hearings and/or give reasons for the delay. Where retraining or other rehabilitation action is proposed, the reason for continued exclusion must be given. The SHA will receive the monthly statistical summary given to Boards and collate them into a single report for the Department of Health.

5.0 The Role of the Board and Designated Board Member

5.1 The Board has a responsibility for ensuring that procedures under this Policy are correctly followed. The Board is also responsible for ensuring the proper corporate governance of the Trust, and for this purpose reports must be made to the Board under these procedures.

5.2 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 takes an overview of the actions of the Case Manager and Case Investigator during the investigation process, and who ensures the momentum of the process is maintained. The Designated Board Member's responsibilities include:

- receiving reports and reviewing the continued exclusion from work of the practitioner;

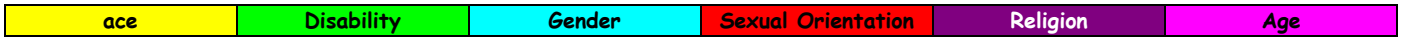
- considering any representations from the practitioner about their exclusion;

- considering any representations about the investigation;

N.B: 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 these procedures are being followed. Only the Designated Board Member should be involved to any significant degree in each review.

6.0 Return to Work

6.1 Where it is decided that the exclusion should come to an end, formal arrangements for the return to work of the practitioner will be followed. The Case Manager and relevant HR Manager, or their nominated representatives, working in close partnership will manage these arrangements. Part of the return to work process must be to ascertain whether clinical and other responsibilities are to remain unchanged or, where restrictions are to apply, what these will be, and any monitoring arrangements to be established to ensure patient safety. Likewise, sufficient support should be made available to enable the practitioner to resume their clinical practice, and this may include a period of retraining and/or supervised practice.


ace
Disability
Gender
Sexual Orientation
Religion
Age

Appendix 3:


Race
Disability
Gender
Sexual Orientation
Religion
Age

APPEAL PANELS IN CAPABILITY CASES

1.0 Context

1.1 Maintaining High Professional Standards in the Modern NHS provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.

1.2. NHS Employers now holds a list of independent appeals panel chairmen to hear appeals under part IV Annex A of 'Maintaining High Professional Standards in a Modern NHS'.

A nationally held list ensures the ability to secure consistency of approach and the ability to monitor performance and assure the quality of panellists.

In cases where an appeal is received under paragraph 28 of the framework, employers should contact sean.king@nhsemployers.org or barbara.carter@nhsemployers.org to arrange for a chairman to be appointed.

1.3 All panellists have met the criteria agreed by the BMA, BDA, DH and NHS Employers. The agreed criteria includes an understanding of the legal framework, jurisdiction and procedures of the panel and equal treatment. They are all experienced in a wide variety of panel and tribunal work and have all proved that they have excellent communication skills and will command the authority required of a panel chair. NHS Employers is responsible for allocating chairmen to panels.

1.4 NHS trusts are responsible for setting up the panel and remuneration should be agreed with the chairman. NHS Employers recommends a figure of around £400 per day, based on rates for other panels within the NHS.

1.5 NHS Employers will ask both parties involved in appeals panel hearings to complete feedback forms which will be used to contribute to the process of reappointment

EQUALITY IMPACT ASSESSMENT
Stage 1. Screening

TRUST POLICY AND PROCEDURES FOR THE HANDLING OF CONCERNS ABOUT THE CONDUCT AND PERFORMANCE OF DOCTORS AND DENTISTS Appendix 4

Name of activity:	TRUST POLICY AND PROCEDURES FOR THE HANDLING OF CONCERNS ABOUT THE CONDUCT AND PERFORMANCE OF DOCTORS AND DENTISTS	Date:	April 2010
Name of person responsible for the activity:	Alan Denton	Directorate:	Human Resources
Names of people undertaking screening:	Alan Denton	Department:	Personnel
Briefly describe the purpose of the activity:	The policy and procedure sets out processes to be followed when conduct or performance of medical staff falls below expected standards (including where this is due to cabability or ill health)		
Who will benefit from this activity?	All staff, through having a clear, fair and non-discriminatory process that applies to all staff whatever their level or category		

	Yes	No	Please give details
1. Could or does the activity affect one or more of the equality groups in a different way to others?		x	Unlike the Trust's general disciplinary and capability policies it is not anticipated that the staff covered by this policy (i.e. medical staff) will include staff with learning difficulties, or, where English is not their first language, who may need additional support to understand and use the policy. (due to the requirements for medical staff to have a high level of ability to converse in and understand the english language)
2. Could or do different equality groups have different needs in relation to the policy?	x		It could be that staff who have or develop a disability may need additional support. The policy does enable staff who have health issues that may explain their conduct, performance or capability to be referred to the Occupational health physician to have an assesment of the extent to which their health (or disability) accounts for the concern identified, and a course of action determined taking this assesment into account. (Section 5 Para 9.3 refers)
3. Does the policy actually or potentially hinder equality of opportunity?		x	
3. Does the policy actually or potentially contribute to equality of opportunity?	x		Policy includes an undertaking to provide additional support to staff who could be disadvantaged, for example, by a disability or ill health.

4. Does the policy offer opportunities to promote equality?	x		Policy includes an undertaking to provide additional support to staff who could be disadvantaged, for example, by a disability or by ill health. The policy also provides the practitioner with independent support via the designated board member, and the NCAS in appropriate cases
5. Does the policy offer opportunities to promote positive relations?	x		Policy includes an undertaking to provide additional support to staff who could be disadvantaged by ill health or disability, and provides independent support (via the role of designated board member) for all individuals who are subject to the policy and procedures contained within it.

Does this activity/policy require further impact assessment, action or amendment?	**No**

Please state in your policy documentation that it has been equality impact assessed and include your completed screening form (FORM A) as an appendix.

Screening form completed by: Alan Denton	When will the policy and screening be reviewed? 2013