Maintaining High Professional Standards at MKUH

(Conduct, Capability, Ill Health and Appeals Policy and Procedures for Practitioners - Doctors and Dentists only)

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To be read in conjunction with the following documents: 1. **Maintaining High Professional Standards in the Modern NHS** http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4103344.pdf 2. **Supporting Doctors to Provide Safer Healthcare: responding to concerns about a doctor's practice** https://www.england.nhs.uk/revalidation/ro/resp-con/		
CQC Fundamental standards: Well led and Safe domains		

Index

Policy Statement

In order to comply with Maintaining High Professional Standards in the Modern NHS (HSC 2003/12), the Trust has implemented this policy and procedure for use at Milton Keynes University Hospital NHS Foundation Trust (MKUH).

Purpose and scope

This policy and procedure applies to all doctors and dentists (referred to as the "practitioners") employed by the Trust, irrespective of grade or department. It does not apply to clinical academics engaged with the Trust through an honorary contract. These procedures supersede all previous Trust and Department of Health procedures including HC90(9), HC(82)13, HSC(94)49 and HM(61)112 in respect of their application to practitioners employed by the Trust.

The right of appeal to the Secretary of State held by some employees under paragraph 190 of their Terms and Conditions of Service are also abolished and replaced by appeal rights contained in this procedure.

This policy and procedure mirrors the national framework for dealing with capability, conduct and ill-health issues for medical and dental staff. This policy framework comprises five parts; providing guidance on the following:

1. Dealing with initial concerns about practitioners
2. Exclusions and/or restrictions of practice
3. Conduct
4. Capability
5. Handling concerns about a practitioner's health

Abbreviations used

NCAS	National Clinical Assessment Service
GMC	General Medical Council
GDC	General Dental Council
SI	Serious incident
HR	Human Resources
MAC	Medical Advisory Committee
LNC	Local Negotiating Committee

1.0 Roles and Responsibilities:

Under these guidelines a number of key Trust individuals may need to be involved. They are:

- the chief executive
- the medical director
- a case manager
- a case investigator
- a designated board member
- the director of workforce
- a clinical advisor
- the responsible officer.

See the definitions of Appendix A for confirmation of these individuals' roles and responsibilities.

2.0 Implementation and dissemination of document

The policy will be disseminated through:

- The Trust Intranet
- Management Board
- Clinical Board
- Joint Local Negotiating Committee
- Medical Advisory Committee

3.0 Processes and procedures

PART 1 INITIAL STEPS WHEN A CONCERN ARISES

1. Raising concerns about a practitioner

If an employee has a concern about the conduct or capability of a practitioner or a patient or relative raises a concern with an employee, he/she should immediately report it to his / her line manager. It is then for that line manager to urgently notify such a concern to the chief executive or medical director. Common sense needs to be applied to whether such concerns are of sufficient substance that they need to be reported. If a line manager is in any doubt, he/she should err on the side of caution and report it to the chief executive or medical director. If necessary, the line manager may consult with the director of workforce prior to notifying the chief executive or medical director.

Concerns about a practitioner's conduct, capability or ill-health can come to light in a number of ways, for example (this list is non-exhaustive);

- Concerns expressed by other NHS professionals, managers, students and non-clinical staff;
- Review of performance against job plans, annual appraisal, revalidation;
- Monitoring of data on performance and quality of care;
- Clinical governance, clinical audit and other quality improvement activities;
- Complaints about care by patients or relatives or representatives of patients;
- Information from regulatory, professional or statutory bodies;
- Litigation following allegations of negligence;
- Information from the police or coroner;
- Court judgments

Unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. All allegations, including those made by relatives of patients, or concerns raised by colleagues, must therefore be properly investigated to verify the facts in order that the allegations can be shown to be true or false.

Concerns about the capability of doctors and dentists in training will be considered initially as training issues and the postgraduate dean will be involved from the outset.

As stated in the NHS England guidance 'Supporting Doctors to Provide Safer Healthcare: responding to concerns about a doctor's practice'. *"For NHS trusts, the basis of this pathway is described in the guidance Maintaining High Professional Standards in the Modern NHS (Department of Health, 2003)."*

2. Appointment of a case manager

Once a concern of substance has been raised with the chief executive or medical director, he/she must ensure that a case manager is appointed. The medical director may designate an appropriate divisional director as case manager. The case manager must be the medical director or acting medical director where the concern relates to a divisional director and/or consultant. In either case a proposed case manager will be "inappropriate" in the event that he/she has had prior substantive involvement in the issue or issues of concern that have arisen. In such a case it shall be another divisional director or medical director (as appropriate) from within the Trust or another Trust who will be nominated by the chief executive or medical director.

3. Restrictions on practice or exclusions

When a concern is raised the possibility of restrictions on practice or exclusions must be considered. This decision will depend upon the nature and severity of the concern in question. In implementing any decision on restrictions or exclusions, the provisions of Part 2 will need to be followed.

4. The case manager's initial assessment

The case manager should carry out a preliminary assessment to establish the nature and seriousness of the concern and whether it is necessary to appoint a case investigator to carry out a full investigation. The case manager shall also form a view as to whether an occupational health referral is required and make the referral, or arrange for it to be made, as appropriate. This preliminary investigation may include short interviews with key witnesses and review of medical notes as well as any other documents relevant to the concern raised. The case manager should seek guidance from the director of workforce, medical director (if he/she is not the case manager) and the NCAS (see Appendices A and B).
Where the case manager decides it is unnecessary to make an immediate decision he/she should set out his or her views on how the matter should be taken forward, in a brief report, "The Initial Assessment Report". Guidance on the format and required content for the case manager's report is at Appendix E.

5. The case manager's recommendations

5.1 If serious concerns are raised

If a serious concern has been raised, the case manager must again consider whether restrictions on or exclusion from practice are appropriate (see Part 2). The case manager will then have to decide whether or not the issues raise serious concerns.

5.2 Serious concerns have not arisen

If the matter is less serious then more informal investigations or processes not involving a case investigator may be initiated. This might involve seeking to agree an NCAS clinical assessment with the doctor in question.

5.3 Timescale for the case manager's recommendations

There will be situations where it is necessary to immediately exclude a practitioner or restrict his/her practice. The case manager must consider this first. Where immediate action is not required, the question of what further steps should be taken remains. The case manager should aim where possible to reach a decision as to his/her recommended action to the medical director or, if the medical director is the case manager, to the chief executive, within 5 working days of the concern being reported to him/her.

6. Action in the event that minor shortcomings are isolated

6.1 Counselling

Minor shortcomings shall initially be dealt with informally. The practitioner's line manager will be responsible for discussing the shortcomings with a view to identifying the causes and offering help to the practitioner to rectify them. Such counselling will not in itself represent part of the disciplinary procedure, although this should be recorded.

6.2 Oral reprimand

In the case of minor infractions, the line manager may give an oral reprimand without a formal disciplinary investigation or hearing for the purpose of improving future performance and behaviour, and in order to assist the practitioner to meet the standards required. The reprimand should be confirmed in writing to the practitioner. In the event that an individual is not content with this action, the formal procedure will normally be followed.
Further advice and guidance on identifying and managing minor shortcomings is available from Human Resources. This is not a formal disciplinary sanction.

6.3 Situations in which ill health was a contributing factor

In situations where a person's ill health is a significant contributory factor to his/her conduct or performance then separate procedures for dealing with ill health and capability would be used. (Further guidance can be obtained from the Ill-Health Procedure at Part 5 below, the Trust's Sickness Absence Policy and Procedure and the Capability Procedure at Part 4 below).

6.4 Action in the event of a pattern of behavior

If a particular pattern of inappropriate behaviour/sub-standard performance has been identified, managers are referred to Part 3 of this policy for further guidance.
Any new, unrelated shortcomings arising during a counselling or review period may be identified, and acknowledged as a separate issue but may be reviewed concurrently.

7. Action in the event that serious shortcomings are isolated

7.1 Appointment of a case investigator

If the case manager considers a formal investigation is needed, the case manager and the medical director, in discussion with the chief executive and the director of workforce shall decide whether to appoint a case investigator.

7.2 Terms of reference

When a case investigator is appointed, the terms of reference for the investigation should be determined by the case manager, usually in consultation with the director of workforce. Guidance on the terms of reference is set out at Appendix F.

7.3 Informing the practitioner

As promptly as possible after the decision to carry out a formal investigation is taken (which should generally be no later than five working days after the case manager's Initial Assessment Report has been finalised), the practitioner should be notified in writing of:

- The fact that an investigation is to be carried out;
- The specific allegations or concerns and/or terms of reference (see 7.2 above) where available;
- The name of the case investigator and where relevant any clinical Advisor;
- Any correspondence relating to the case together and, if known, the provisional list of people to be interviewed by the case investigator;
- The practitioner's right to meet the case investigator to put his/her views;
- His/her right to be accompanied (see Part 1 of this policy).

8. Carrying out an investigation

8.1 Time limit for carrying out the investigation

The case investigator should complete his/her investigation within 4 weeks of his/her appointment and submit the report to the case manager within a further 5 working days.
In circumstances where a case investigator cannot meet the four-week target, he/she should, as soon as this is realised, notify in writing BOTH the case manager and then the practitioner in question explaining the reasons why. A revised timetable should be provided in addition to an explanation.

8.2 Procedure for carrying out the investigation

The case investigator has a wide discretion in how he/she carries out the investigation so long as he/she establishes the facts in an unbiased way and adheres to the terms of reference.
Where a question of clinical judgement is raised during the investigation process, the case investigator must formally involve a senior member of the medical or dental staff. Where no other suitable senior doctor or dentist is employed by the Trust a senior doctor or dentist from another NHS body should be involved.
The case investigator should seek assistance from a senior member of the Human Resources Department where appropriate.
Where concerns trigger the Trust's Serious Incidents Policy ("SI"), the case investigator should liaise with the Clinical Governance team to agree the approach to be taken to such investigations.

8.3 Action in the event that new issues arise during the course of the investigation

In the event that new issues of concern arise during the investigation, the case investigator will inform in writing the case manager of the nature of the new issues that have arisen and supply the supporting evidence. The case manager, in consultation with the director of workforce, will decide whether to amend the terms of reference to cover the new issues of concern. In the event that the terms of reference are to be varied, the practitioner will be provided with the amended terms

of reference in the form set out at Appendix F below, together with an explanation of why the terms of reference were varied.
The time limit for completion may be reviewed to take into consideration the time required to explore the new issues fully. The case investigator should, however, still strive to complete their investigation within four weeks of the terms of reference being amended.

9. The Case Investigator's Report

9.1 The content of the case investigator's report

Once the investigation has been completed the case investigator must prepare his/her written report, with the clinical Advisor's assistance if necessary. Guidance on the content and format of the report is at Appendix E. The report should provide the case manager with enough information to decide whether:

- there is a case of misconduct to put to a conduct panel (see Part 3 of this policy);
- there are concerns about the practitioner's health to be considered by the Occupational Health department (see Part 5 of this policy);
- there are performance concerns to be further explored with the NCAS;
- restrictions on practice or exclusion from work need to be considered (see Part 2 of this policy);
- the concerns should be referred to the General Medical Council ("GMC") or General Dental Council ("GDC");
- the matter should be dealt with under the capability procedures (see Part 4 of this policy); or
- no further action is needed.

9.2 The right of the practitioner to comment on the factual parts of the report in capability cases

Before a final report into concerns about capability is provided to the case manager, the case investigator must provide the factual parts of his/her report to the practitioner for comment. The practitioner has 10 working days in which to comment on the report unless an alternative timescale is agreed in writing with the case manager.
If the practitioner (or his/her representative) fails to provide his or her comments within the 10 working day time limit or such other time limit as may be agreed with him/her, the case investigator will finalise his/her report, recording the fact that it has not been possible to obtain the practitioner's comments.
The right to comment on the factual aspects of the case investigator's report shall be limited to cases concerning the capability of a practitioner and shall not extend to other kinds of allegation.

9.3 Decision of the case manager

Once the report is completed it must be provided to the case manager who will then decide which of those courses of action set out above needs to be taken in the light of it. The case manager should discuss the report with the chief executive and director of workforce, as well as with the NCAS.
The case manager will write to the practitioner enclosing a copy of the report together with the statements and other evidence gathered in the course of the investigation. The letter must set out the case manager's decision and the reasons for it. (See Part 4, paragraph 3 in relation to capability procedure).

PART 2 EXCLUSIONS OR RESTRICTIONS OF PRACTICE

1. Introduction

Under this procedure a practitioner is not suspended, he/she can only be excluded from work. The word suspension should not be used when dealing with a practitioner as this can be confused with action taken by the GMC or GDC to suspend the practitioner from the register, pending a hearing of their case or as an outcome of a fitness to practice hearing. Exclusion is a last resort and can only be justified on the grounds set out below. Before the decision is taken to exclude any practitioner, all other options must have been thoroughly explored, for example restricting a practitioner's duties.

2. Roles of Officers

2.1 Power to exclude or restrict a Practitioner

The chief executive has overall responsibility for managing exclusions and restrictions.

- A decision to exclude or restrict a practitioner can only be made by:
- the chief executive (or anyone acting in that capacity);
- the medical director (or anyone acting in that capacity);
- the director of workforce (or anyone acting in that capacity); or
- the divisional directors (only for practitioners below the grade of consultant).

2.2 Responsibilities of individual officers in the event of a restriction or exclusion

2.2.1 The case manager

It will usually be for the case manager to make the initial decision whether to exclude or restrict a practitioner. However there may be circumstances where this may not be possible in which case the officers listed in paragraph 2.1 will be empowered to make this decision. A decision to exclude a practitioner will only be made once it has been decided that there are significant concerns about the practitioner's conduct or capability and the conditions set out in paragraph 0 below have been satisfied. The case manager shall also form a view as to whether an occupational health referral is required and make the referral or arrange for it to be made, as appropriate.

The case manager will review the exclusion or restriction with the designated Board member and chief executive as set out below, taking into consideration any information that may be provided to him/her by the case investigator.

2.2.2 The Designated Board Member

The designated Board member shall oversee the exclusion or restriction process. This role will include ensuring that the applicable time limits are complied with, as well as receiving representations on the process or procedure leading to the exclusion or restriction.

2.2.3 The case investigator

The case investigator shall from time to time provide such information to the case manager as may be relevant to the review of the decision to exclude or restrict the practitioner.

3. The restrictions that can be imposed on the practitioner

If a serious concern is raised about a practitioner, the case manager must consider at the outset if temporary restrictions on the practitioner's practice are necessary. There are four alternative types of restriction:

- Obtaining voluntary undertakings from the practitioner on what he/she will and will not do;
- Placing the practitioner under the supervision of a divisional director or medical director;
- Amending or restricting clinical duties; and
- Restriction to non-medical duties.

If there is evidence that concerns are related to the practitioner's health, the Occupational Health Department should become involved at an early stage to help with the investigation of specific health problems and to advise the case investigator accordingly (see Part 5 of this policy).

4. Where exclusion may be justified

Exclusion is a temporary measure reserved for specific circumstances. Alternatives to exclusion must always be considered in the first instance. Exclusion is only potentially justified where:

- There has been a critical incident where serious allegations have been made; or
- There has been a breakdown in relationships between a colleague and the rest of the team; or
- The presence of the practitioner is likely to hinder the formal investigation.
- The key factors in any decision to exclude are:
- the protection of staff or patient interests; or
- to assist the investigative process.

5. The process for deciding whether to exclude or restrict

There are two types of exclusion: immediate exclusion dealt with in paragraph 6 below, and formal exclusions which are dealt with under paragraph 7. In addition, restrictions of practice may be imposed.

Before reaching the decision to formally exclude, it is important to seek the NCAS's assistance. However, ultimately the decision on restriction(s) or exclusion rests with the Trust's authorised officers as set out in paragraph 2.1

Where the officers of the Trust disagree with the NCAS, the reasons for this divergence in view should be carefully recorded in writing.

Any decision to exclude formally should be discussed with the chief executive, the director of workforce and the medical director (if not the case manager).

The designated Board member should be informed of any such decision. A decision to exclude immediately should, where practicable, follow the same procedure, although, in the event that this is not practicable, the officer designated under paragraph 2.1 shall discuss the decision as soon as practicable with the chief executive and director of workforce, and confirm that decision to the designated Board member.

6. Immediate exclusion

6.1 The right to exclude immediately

In a circumstance referred to in paragraph 0 above, where no alternative is deemed appropriate by the officers listed at paragraph 2.1, the practitioner may be excluded immediately to allow preliminary consideration of the concern by the case manager and case investigator.

6.2 The initial period of immediate exclusion

An immediate exclusion can be for a maximum of two weeks following which a decision whether to exclude formally must be made in accordance with the procedure set out in paragraph 7 below. If the decision is to restrict a practitioner's practice, it should also be reviewed, though it is recommended this happens when the case investigator has completed his/her report.

6.3 Meeting with the practitioner

The practitioner should be informed at a meeting that they are being excluded immediately together with the broad reasons for the exclusion. A date should be agreed to meet again within the two weeks commencing on the date of the exclusion. The meeting should be immediately followed by a letter confirming the outcome of that meeting and the practitioner's rights of representation.

Appendix C is a form to be completed on making an initial assessment of what measures to take.

Appendix D is a template letter to send to a practitioner in these circumstances.

7. Formal decisions to exclude or restrict practice

7.1 The right to exclude formally

A formal exclusion can only take place after:

- A preliminary report has been prepared by the case investigator which confirms there is misconduct/capability concern or further investigation is warranted;
- The case manager, if possible, provisionally assesses whether there is a case to answer;
- A meeting has been held with the practitioner in accordance with paragraph 7.4; and
- The NCAS has been consulted.

7.2 Justification of the decision to exclude formally

Formal exclusion can only be justified where there is a need to protect patient or staff interests pending the full investigation of:

- Allegations of misconduct;
- Concerns about serious dysfunction in the operation of clinical services;
- Concerns about lack of capability or poor performance of sufficient seriousness that it is warranted to protect patients; or
- Where the practitioner's presence is likely to hinder ongoing investigations.

Other options such as restrictions of practice must be considered. Exclusion is to be used only where it is strictly necessary for the reasons set out above.

7.3 Considerations in a decision to exclude formally

The checklist set out at Appendix C should be completed where considering a formal exclusion/restriction.

7.4 Meeting with the practitioner

The practitioner should be informed of the exclusion in a meeting with the medical director and/or the case manager. A senior human resources business partner (or deputy director of workforce) should be present at this meeting where possible. The reasons for the exclusion must be explained and the practitioner shall have an opportunity to respond and suggest alternatives to exclusion.

7.5 Confirming formal exclusion in writing

Formal exclusion must be confirmed in writing to the practitioner within five working days, where practicable, of the decision being taken. This letter must state:-

- the duration of the exclusion;
- the nature of the allegations being made;
- the terms of the exclusion;
- a full investigation or other action will follow; and
- that the designated Board member may receive any representation on the exclusion. (See Appendix D - Template letter to send to a practitioner in these circumstances).

A formal exclusion can last for a maximum of four weeks at which point it must be reviewed (see paragraph 12 below).

8. Exclusion from Trust property

A case manager must decide if exclusion from Trust property is necessary, as exclusion may not necessarily involve an exclusion from the Trust property. An exclusion from Trust property is necessary where there is a risk the practitioner will tamper with evidence or seek to influence colleagues. Patient safety must come first; if there is a risk of disruption to clinical services by the practitioner's presence, he/she should not be allowed onto Trust property. Where possible, an excluded practitioner should be allowed on Trust property for continuing professional development purposes. He/she should ordinarily be allowed on Trust property as a patient. As an alternative to complete exclusion from Trust property, the case manager may consider a limited exclusion from certain parts of Trust property. In the event that such an exclusion is put in place but then breached by the practitioner, a full exclusion may be substituted.

9. Practitioner's duties if excluded

An excluded practitioner must be ready, willing and able to carry out some or all of his/her duties during contractual hours. He/she must be available to assist the case investigator during these hours. He/she must obtain permission to take annual or study leave from the case manager.

10. Obligations on the practitioner in the event exclusion is considered

10.1 Duty to co-operate

A practitioner should co-operate with the Trust in finding alternatives to exclusion by:

- agreeing to restrictions on his/her practice, including a restriction to non-clinical duties;
- agreeing to not interfere with investigations involving him/her;
- agreeing to give undertakings not to carry out certain work. The NCAS may recommend such undertakings extend beyond the Trust to the public and private sector;
- agreeing to work under supervision.

10.2 Duty on the practitioner to provide information

An excluded practitioner must notify the case manager of any other organisations for whom they undertake voluntary or paid work during the period of exclusion. The practitioner must seek prior consent from the case manager to continue to undertake such work. In such cases, the case manager must inform the medical director (or Responsible Officer) who will make arrangements to notify other organisations for whom the practitioner undertakes voluntary or paid work, before consent is granted.

10.3 Duty to provide written commitments

A practitioner should be prepared to give any of these commitments in writing to ensure there is no confusion about them. If a practitioner refuses to give any such commitments if asked to, that is a factor a case manager can legitimately take into account when deciding whether to exclude or not.

11. Consequences of non-compliance with the practitioner's duties

In the event the practitioner fails to comply with his or her duties under paragraphs 9 and 10 above, (s)he may be subject to disciplinary action on the grounds of failure to comply with a reasonable management instruction.

12. Reviewing exclusions and the role of the Trust Board

12.1 First Review

The Case manager must initially review the practitioner's formal exclusion before the expiry of four weeks from the decision to exclude and:

- submit a written advisory report of the outcome of that review to the chief executive / the Trust Board;
- document the renewal;
- send written notification of the renewal to the practitioner.

Any change of circumstances since the original decision to suspend must be addressed by the case manager in his/her written review report. This review report should be provided to the practitioner under investigation, the chief executive and the Trust Board.

12.2 Second Review (and reviews after the Third Review)

Before expiry of a further four weeks from the date of the previous review, the case manager must review the exclusion and follow the steps detailed under the first review above.

12.3 Third Review

If an exclusion continues for a further four weeks from the second review, a third review should be carried out.
If an investigation has been completed showing there is a case to answer, prompt steps need to be taken to set up the appropriate hearing to consider the case.
If a practitioner has been excluded for three periods and the investigation has not been completed, the case manager must:

- Submit a written report to the chief executive including:-
  - the reasons for the continued exclusion;
  - why restrictions on practice are not appropriate;
  - the timetable for completing the investigation.

- Formally refer the matter to the NCAS confirming:-
  - why exclusion remains appropriate; and
  - the steps taken to conclude the exclusion.

The chief executive must report the reason for the continued exclusion and the steps taken to conclude the exclusion to the designated Board member.

The NCAS will review the case and advise the Trust on handling the case.

12.4 Six Month Review

Exclusions should not normally last for more than six months unless a criminal investigation is ongoing. If it does, the steps outlined above under third review should be repeated.

12.5 Reviews after Six Months

In the exceptional circumstances whereby exclusion exceeds six months, monthly reviews should continue as outlined under first review at paragraph 12.1

13. Role of the Board

The Trust Board's responsibility, having been informed via the Designated Board Member, is to ensure the procedures set out above are followed but no more. The Trust will add as a standing agenda item for the closed part of Trust Board meetings a review of excluded/restricted practitioners, when applicable. The Board should assess if proper progress is being made with investigations and that those people who should be involved are involved. The case manager should have a monthly statistical report prepared for the Board showing all exclusions, their duration and the number of times they have been reviewed or renewed.

14. Police involvement

Where any allegations give rise to potential criminal allegations the director of workforce should be consulted at the earliest opportunity. Police investigations are not necessarily a bar to continued internal investigations. However, if the Police do not consent to the Trust continuing with an investigation, the Trust must cease that investigation.

15. Reporting matters outside the Trust

If a practitioner may represent a risk to patients, the Trust has a duty to notify the public and private sector organisations of this. Where details of other employers are not readily available to the Trust, the practitioner is obliged under paragraph 0 to provide this information. Failure to do so may result in disciplinary action as well as possible referral to the GMC/GDC. Ordinarily, this should be undertaken with in collaboration with the Responsible Officer and following discussion with the GMC Employment Liaison Adviser.

16. Breach of a restriction

Where a restriction has been placed on the practitioner's practice, they shall agree not to undertake any work in that area of practice with any other organisation whether on an employed basis or otherwise and whether in the private or public sectors. If a practitioner breaches an undertaking he/she has given the case manager should consult with the GMC/GDC on whether an alert letter should be issued. Guidance on issuing an alert letter is contained in HSC 2002/011. This breach of an undertaking may also give rise to disciplinary action against the practitioner.

17. Reporting to the GMC / GDC

At the point where serious allegations affecting patient safety arise, the case manager has a duty to consider reporting the matter to the GMC/GDC. This could be at the stage of immediate exclusion or when the case investigator's report has been provided. In either instance any such referral should be notified to the practitioner. Ordinarily, this should be undertaken with in collaboration with the Responsible Officer and following discussion with the GMC Employment Liaison Adviser.

PART 3 CONDUCT PROCEDURE

1. Introduction

At the initial stage set out in paragraph 4, Part 1 the Case Manager should consider whether the concern may amount to an issue of conduct. This may not be a final decision, and the Case Manager should review this decision on receipt of the Case Investigator's report (paragraph 9, Part 1).

Any concerns relating to practitioners in training grades must be discussed with the relevant educational supervisor and college or clinical tutor, together with the post graduate dean at the outset.

2. Definition of Misconduct

Examples of misconduct will vary widely but may fall into one of the following broad categories:

- A refusal to comply with reasonable requirements of the Trust;
- An infringement of the Trust's disciplinary rules including standards of professional behaviour required by the relevant regulatory body;
- Commission of criminal offences outside the work place;
- Wilful, careless, inappropriate or unethical behaviour likely to compromise standards of patient care or safety or likely to create serious dysfunction to the effective running of the service;
- A failure to fulfil contractual obligations; or
- Failing to provide proper support to other members of staff.

The Trust's **values, standards, commitments and behaviours** represent the minimum level of behaviour required of staff. Breaches of these are also likely to be considered as misconduct.

Examples of gross misconduct are included in the Trust's disciplinary policy and procedures. As a general rule a practitioner should not be dismissed for a first offence unless it is one of gross misconduct.

3. Investigation of allegations

Every allegation must be fully investigated. Where the alleged misconduct involves matters of a professional nature, the Case Investigator should obtain independent advice from a senior clinician in the same speciality as the practitioner.

The investigation process will be carried out in accordance with paragraph 8, Part 1 above.

4. Classification of the concern

The Case Manager will, on receipt of the Case Investigator's report and having consulted with the NCAS, the medical director, the director of workforce, and the chief executive, consider the classification of the concerns about the practitioner.

If the Case Manager concludes that the concern is one of conduct the remainder of this Part of this policy section will be followed. If the concern is one of capability, Part 4 should be followed. If the concern is one of health, Part 5 should be followed.

The classification will be confirmed to the practitioner in writing in the letter confirming the outcome of the investigation (see paragraph 9, Part 1) along with the Case Manager's conclusions.

5. Criminal Proceedings

5.1.1 Action by the Trust during a Police investigation

Where the Trust's investigation finds a suspected criminal act, this should be reported to the police.

Where the police investigate the allegation, the Trust's own investigations should only proceed after having consulted with the police to ensure the continuation of the investigation and the alleged incident would not impede the investigation. If the Police do not consent to the Trust continuing with an investigation, the Trust must accede to this request.

5.1.2 Action by the Trust in the event that criminal charges are successful

In a circumstance where criminal charges have been successfully brought against the practitioner, the Trust will need to carefully consider whether they render the practitioner unsuitable for further employment. The Trust will need to consider the overall circumstances of the conviction and in particular the safety of patients, staff and members of the public and whether exclusion and further investigation is necessary.

5.1.3 Action in the event of acquittal or insufficient evidence

Where a criminal case is pursued but the practitioner is acquitted or where there was insufficient evidence to take the matter to court, there is a presumption that the practitioner will be reinstated.

The Trust must however consider whether there is enough evidence to suggest that there is a threat to patients, staff or members of the public. If the Trust believes this to be the case, the alleged misconduct should be addressed under these procedures. This is so even though the criminal process resulted in the acquittal of the practitioner.

6 Misconduct hearings and disciplinary matters

6.1 When the Case Investigator's report is received by the Case Manager and it contains potential issues of misconduct, the Case Manager must determine if there is a case of misconduct for the practitioner to answer.

6.2 If the Case Manager, after consulting again with NCAS, determines that there is indeed a case of misconduct that should be put to a panel under the Trust's disciplinary policy and procedure, then the process will no longer be governed by this Policy; it will instead be addressed under the Trust's disciplinary policy and procedure

6.3 Where a case involving issues of professional misconduct proceeds to a hearing under the Trust's disciplinary policy and procedure the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the Trust.

6.4 It is for the Trust to decide upon the most appropriate way forward, having consulted the NCAS. If a practitioner considers that the case has been wrongly classified by the Case Manager as misconduct, he or she may make representations to the Designated Member who will review the categorisation.

PART 4 CAPABILITY PROCEDURE

1. Introduction

Initial consideration must be given as to whether any failure or concern in relation to a practitioner was due to broader systems or organisational failure. If so, appropriate investigation and remedial action should be taken.

If the concerns do relate to the capability of an individual practitioner, these should be dealt with under this procedure whether arising from a one-off or series of incidents.

Where appropriate, issues of capability shall be resolved through ongoing assessment, retraining and support. If the concerns cannot be resolved routinely by management, the NCAS must be contacted for support and guidance. If the NCAS does not deem it appropriate to conduct an assessment and/or construct an action plan for the practitioner then the matter will proceed to a Capability hearing.

Any concerns relating to practitioners in training grades must be discussed with the relevant educational supervisor and college or clinical tutor, plus with the postgraduate dean from the outset.

2. Definition of Capability

The following are examples of matters which the Trust may regard as being concerns about capability (this is a non-exhaustive list):-

- Out of date or incompetent clinical practice (unless this is contrary to clear management requests made previously in which case the issue may be one of misconduct – see Part 3 of this policy);
- Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- Inability to communicate effectively;
- Inappropriate delegation of clinical responsibility;
- Inadequate supervision of delegated clinical tasks; and
- Ineffective clinical team working skills.

In the event that the capability issue has arisen due to the practitioner's ill health, then the Ill Health Procedure in Part 5 of this policy must be considered.
In the event of an overlap between issues of conduct (see Part 3) and capability, then usually both matters will be heard under the capability procedure. In exceptional circumstances, it may be necessary for issues to be considered under separate procedures. The decision as to which procedure shall be initiated shall be taken by the case manager in consultation with the director of workforce, and the NCAS.

3. Pre-Capability Hearing Process

Once the case investigator has concluded his/her investigation (see Part 1, paragraphs 8 and 9) the report will be sent to the case manager. The case investigator will already have provided the practitioner with the opportunity to comment on the factual sections of the report in accordance with Part 1, paragraph 9.2 above.

The case manager shall decide on the action that needs to be taken, shall consult with the NCAS and within 10 working days notify the practitioner in writing on how the issue is to be dealt with.

If it is decided to apply the capability process in this Part 3, the options available to the case manager for dealing with the matter are:

- No action is required;
- Retraining or counselling should be undertaken;
- The matter should be referred to the NCAS to deal with the case by way of an assessment panel; or
- Referral to a capability panel for a hearing should be made.

If the concerns cannot be resolved routinely by management, the NCAS must be contacted for support and guidance. If the NCAS does not deem it appropriate to conduct an assessment and/or construct an action plan for the practitioner then the matter will proceed to a capability hearing.

If NCAS does deem it appropriate to conduct an assessment, and determines that an action plan will assist, then NCAS will be asked to support the case manager to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified.

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

The action plan must be agreed by the practitioner and the Trust and provided it can be agreed, the case manager will take reasonable steps to ensure that it is implemented. The action plan will be monitored for such period as deemed appropriate by the case manager and if, in the reasonable opinion of the case manager, the practitioner's performance has not sufficiently improved within that period, then the matter will proceed to a capability hearing.

If the practitioner does not agree to the case being referred to NCAS, or fails to comply with an action plan that has been agreed, then the matter will proceed to a capability hearing. Either of these circumstances may necessitate disciplinary action and consideration of referral to the GMC or GDC by the case manager.

4. Preparation for Capability Hearings

4.1 Time Limits

Where a case manager has decided to refer the matter to a capability panel, the following preparatory steps must take place:

- 20 working days before the hearing the case manager will notify the practitioner in writing of the decision to arrange a capability hearing.

- The practitioner must at the same time be provided with details of the allegations and copy documents or evidence that will be put before the capability panel and confirmation of his/her right to be accompanied.

- At least 10 working days before the hearing, both parties should exchange documents (including any written statements of case) and witness statements on which they intend to rely at the hearing. In the rare circumstance where either party intends to rely upon a witness but does not have a witness statement, they must provide a written synopsis of the evidence that witness will provide. This synopsis must contain the key elements of the witness evidence and be provided at least 10 working days before the hearing.

- At least 2 working days before the hearing, the parties must exchange final lists of witnesses they intend to call to the hearing. The Chairman of the panel can invite the witness to attend where a witness' evidence is in dispute. Witnesses may be accompanied to the hearing but the person accompanying them may not participate in the hearing. Where only a synopsis of the witness' evidence has been provided in advance, the witness must provide evidence in person at the hearing unless the synopsis of evidence has been explicitly agreed by the other party.

4.2 Postponement Requests

In the event of a postponement request, the case manager shall deal with the response and may agree time extensions. If the practitioner requires a postponement of over 30 working days, the Chairman of the capability panel should consider the grounds for the request and if reasonable to do so may decide to proceed with the hearing in the practitioner's absence.

4.3 Panel Members

The panel for the capability hearing shall consist of at least three people including:

- An executive director of the Trust;
- A medical or dental practitioner not employed by the Trust (following discussions with the LNC on an advisory basis);
- A Board member or senior manager of the Trust.

The Executive Director will normally act as Chairman of the panel.

If the practitioner is a clinical academic, a further panel member may be appointed in accordance with any agreed protocol between the Trust and the relevant University. The panel must be advised by:-

- A senior member of staff from HR.

- A senior clinician from the same speciality as the practitioner from another NHS employer. In the event this clinician cannot advise on the appropriate level of competence then a practitioner from another NHS employer of the same grade as the practitioner in question should be asked to advise.

The practitioner should be notified of the panel members in writing by the case manager, where possible at the same time as the notification of the hearing.

Within **5 working days** of their notification, the practitioner should raise with the case manager any objections to the panel members. The case manager in consultation with the Trust's director of workforce shall consider the objections and will respond in writing prior to the hearing, stating the reasons for any decision on the objections. Reasonable efforts will be made by the Trust to agree the composition of the panel and only in exceptional circumstances shall the hearing be postponed whilst the matter is resolved.

5. The Capability Hearing

The Chairman of the panel is responsible for ensuring the hearing is conducted properly and in accordance with the Trust's procedure.

The practitioner has the right to be accompanied at the hearing (see Part 1). The case manager may be assisted by the case investigator(s) (where they are not appearing as a witness) or an HR business partner.

At all times during the hearing the panel, its Advisors, the practitioner, his/her representative and the case manager must be present. Once a witness has given evidence he/she shall leave the hearing.

The procedure for the hearing will be as follows:

- The case manager presents the management case (which may be by reference to the case investigator's report or a separate statement of case);

- The management witnesses will be called in turn.

    - Each will confirm their witness statement and provide any additional information.

    - The case manager may ask additional questions.

    - The practitioner's representative may ask questions of the witnesses (if unrepresented the practitioner may ask questions).

    - The panel may question the witness.

    - The case manager may then ask further questions to clarify any point but will not be able to raise new evidence;

- The Chairman may ask the case manager to clarify any issues arising from the management case;

- The practitioner and/or their representative shall present their case and call any witnesses. The above procedure used for the management's witnesses shall be followed;

- The Chairman can request any points of clarification on the practitioner's case;

- The Chairman shall invite the case manager to make a short closing statement summarising the key points of the management's case;
- The Chairman shall invite the practitioner and/or his/her representative to make a short closing statement summarising the key points of their case. Where appropriate, this should include any grounds of mitigation;

- The panel shall retire to consider its decision.

6. The Decision

The panel has the discretion to make a range of decisions. A non-exhaustive list of possible decisions include:

- No action required;

- Verbal agreement by the practitioner that there will be an improvement in clinical performance within a specified timescale confirmed in a written statement as to what is required and how it is to be achieved;

- Written warning to improve clinical performance within a specified timescale with a statement which is required and how this can be achieved;

- A final written warning that there must be improved clinical performance within a specified timescale and how this can be achieved;

- Termination of employment.

The decision must be confirmed in writing to the practitioner within **5 working days** of the hearing and communicated to the case manager within the same timescale. The letter to the practitioner must include reasons for the decision, confirmation of the right of appeal and notification of any intention to make a referral to the GMC/GDC or any other external professional body.
Any decision must be placed in the practitioner's personal file. As general guidance a verbal agreement should remain on the file for six months and written warnings for twelve months.

7. Capability Appeals Procedure

7.1 Remit of the Appeal Panel

This appeal procedure shall relate to decisions of a capability panel. The remit of the appeal panel is to review the findings and procedure followed by the capability panel. A full re-hearing of all evidence should not take place unless the Chairman of the appeal panel considers that proper procedures have not been followed at an earlier stage in the process and a full re-hearing is required in the interests of a fair process.

The appeal panel can hear any new evidence submitted by the practitioner to consider whether this might have significantly altered the capability panel's decision. The case manager may call new evidence that is relevant to new evidence called by the practitioner and/or his or her representative.

7.2 The Appeal Panel

The appeal panel should consist of:-

- An independent person (trained in legal aspects of appeals) from an approved pool appointed by NHS Improvement or equivalent/relevant NHS body (formerly NHS TDA and NHS Appointments Commission). This person will act as the Chairman of the appeal panel;

- The Trust's Chairman or another non-executive director (other than the designated Board member);

- A medically/dentally qualified member who is not employed by the Trust (following discussions with the LNC/Medical Staff Committee).

Where the practitioner is a clinical academic, a further panel member may be appointed in accordance with any agreed protocol between the Trust and the relevant University.

The appeal panel may be advised by:-

- A consultant from the same speciality or sub-speciality of the practitioner who is not employed by the Trust; and
- A senior HR specialist.

The panel will be established by the Trust and advice should be sought from the director of workforce.

The practitioner shall be notified of the composition of the panel, where possible, 25 working days prior to the hearing. If the practitioner objects to a panel member, the director of workforce shall liaise with him/her or their representative to seek to reach agreement. In the event agreement cannot be reached, the objections will be noted.

7.3 Procedure and Time Limits in Preparation for the Appeal Hearing

The following steps shall be taken:-

- Within **25 working days** of the practitioner receiving the capability panel's decision he/she must send an appeal statement to the Trust's director of workforce giving full grounds for the appeal;

- Within **25 working days** of the appeal being lodged, the appeal hearing shall take place;

- At least **10 working days** before the appeal hearing, the appeal panel shall notify the parties if it considers it is necessary to hear evidence from any witness. In the event the panel requires a witness to be called, the Chairman shall liaise with the Human Resources Department for the witness to supply a written statement to both parties **5 working days** in advance of the hearing;

- At least **10 working days** before the hearing the practitioner shall confirm to the panel and the case manager whether he/she has any additional evidence on which he/she intends to rely. Copies of any documents or witness statements shall be provided with the notice of intention to call additional evidence.

- At least **5 working days** before the hearing, the case manager shall confirm to the panel and the practitioner whether he/she has any additional evidence on which he/she intends to rely. Copies of any documents shall be provided. If the case manager's response to the practitioner's grounds of appeal is other than as set out in the written decision of the capability panel, the case manager must provide this response, in written form, to the practitioner no later than **5 working days** before the appeal hearing.

7.4 Procedure at the Appeal Hearing

The procedure for the hearing will be as follows:-

- The practitioner or his/her representative shall present a full statement of their case to the appeal panel which shall include all the grounds of appeal;

- The case manager and the panel shall be entitled to question the practitioner or his representative on the grounds of appeal;

- The practitioner or his/her representative shall present any additional evidence/witnesses. If they do so, the case manager and panel may ask questions;

- The case manager shall present a statement of the management case to the appeal panel which shall include the response to the grounds of appeal;

- The practitioner and the appeal panel shall be entitled to question the case manager;

- The case manager shall present any additional evidence/witnesses in relation to any new evidence from the practitioner or his/her representative and the panel may ask questions;

- The case manager shall sum up the management's case;

- The practitioner or his/her representative shall sum up their case. At this stage a mitigation statement may be made.

- The appeal panel shall retire to make a decision.

7.5 The Decision of the Appeal Panel

The appeal panel may:-

- Confirm the original decision of the capability panel;
- Amend the decision of the capability panel; or
- Order the case to be reheard in its entirety.

The appeal panel's decision and the reasons for it must be confirmed in writing to the practitioner within 5 working days of the appeal hearing. A record of the decision shall be kept on the practitioner's personnel file including a statement of the capability issues, the action taken and the reasons for those actions.

Where the appeal was about the practitioner's dismissal, he/she will not be paid from the date of termination as decided by the original capability panel. If the practitioner is reinstated following the appeal his/her pay shall be backdated to the date of termination of employment.

If the appeal panel decided that the whole case is to be reheard, the practitioner shall be reinstated and be paid backdated salary to the date of termination. In this situation any conditions/restrictions on practice in place at the time of the original capability hearing shall be applied.

8. Other Issues

8.1 Termination of Employment Pre-completion of Process

If a practitioner leaves the Trust's employment prior to the conclusion of the above processes, the capability proceedings must be completed wherever possible. This applies whatever the personal circumstances of the practitioner.

If the practitioner cannot be contacted via their last known address/registered address, the Trust will need to make a decision on the capability issues raised based on the evidence it has and take appropriate action. This decision shall be made by the chief executive in conjunction with the case manager, director of workforce and in consultation with the designated Board member. This action may include a referral to the GMC/GDC, the issue of an alert letter and/or referral to the police.

8.2 Sickness Absence of the Practitioner

Where during the capability process a practitioner becomes ill, they shall be dealt with under the Trust's sickness absence procedure and Part 5 of this policy.

Where a practitioner's employment is terminated on ill health grounds the Trust shall take the capability procedure to a conclusion as set out in paragraph 6 above

PART 5 HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH

1. Introduction

This part should be read in conjunction with the trust's Sickness Absence Policy and applies to the following circumstances:

- where the issues of capability or conduct are decided by the case manager to have arisen solely as a result of ill health on the part of the practitioner;
- where issues of ill health arise during the application of the procedures for addressing capability or conduct.
- Where the practitioner is off sick and no concerns have arisen about conduct or capability; the provisions of the trust's Sickness Absence Policy shall apply.

Separate procedures are set out below in respect of each of these eventualities.

2. Action in the event the practitioner is absent purely due to ill health and no concerns exist as to conduct or capability

2.1 Procedure

Where a practitioner has been off sick for a continuous period of four weeks and there is no anticipated date for the practitioner's return to work and no concerns about capability or conduct have arisen, the following procedure will be adopted:

- A case manager will be appointed in accordance with Part 1 of this policy;
- The case manager will refer the practitioner to Occupational Health for assessment;
- Occupational Health will provide an assessment to the Trust and make recommendations as regards future management of the practitioner's ill health or proposals for re-integration of the practitioner into work;
- The case manager will seek the advice of the NCAS about the report and management of the practitioner's ill health;
- The practitioner (together with his/her representative if the practitioner so wishes) will meet the case manager (who will be accompanied by a member of Human Resources if (s)he wishes) to discuss the occupational health report and proposals for the practitioner to return to work;
- If the practitioner is unable to attend a meeting due to the state of his or her health, his/her ill health will continue to be monitored by the case manager in conjunction with Human Resources;
- The case manager, in conjunction with Human Resources and the NCAS, shall monitor the practitioner's sickness and explore all of the options, including re-training, rehabilitation, variation of duties and/or working patterns, with the practitioner and his/her representative;

- As a last resort, in the event that the practitioner will be unable to return to work within a reasonable time and no reasonable steps can be taken by the Trust to facilitate that return, the practitioner's employment may be terminated.

2.2 Obligations of the Trust and the Practitioner

The Trust agrees that it will explore all options with the practitioner and seek to make reasonable adjustments to facilitate his or her return to work.

The practitioner agrees that (s)he will make himself/herself reasonably available for meetings or appointments with Occupational Health or such other medical Advisor as may be reasonably deemed necessary or appropriate by the Trust.

3. Action in the event that issues of capability or conduct arise solely as a result of ill health on the part of the Practitioner

In the event that the case manager considers that the capability or conduct concerns may have arisen because of a practitioner's ill health, he/she should refer the practitioner to Occupational Health. It needs to set out:

- The practitioner's role and duties within it.
- If the practitioner has been signed off sick? If so, for how long and for what reason?
- Any evidence the practitioner has put forward suggesting that the concerns are caused by health problems rather than misconduct or incapability.
- Enough of the background about the concerns so that the occupational health Advisor understands the context in which he/she is asked to advise.
- Specific questions asking the occupational health Advisor to assess whether the ill health in question could have caused the practitioner to behave in a particular way and if that is likely in the particular case.
- Whether the practitioner is currently fit to carry out his/her duties. If not, when might he/she be fit to do so? Does his/her ill health compromise or potentially compromise patient safety? If so, how long will that be the situation or when will the Occupational Health Advisor need to review the position and give further advice? Will the practitioner be able to return on a restricted basis without jeopardising patient safety and, if so, when?
- A request for a written report from occupational health addressing each of the questions raised.

If the practitioner refuses to co-operate in such an occupational health assessment, that may well be a refusal to obey a reasonable management instruction to be dealt with under Part 3 of this procedure.
Once the case manager has the report from Occupational Health, he/she should decide whether he/she is satisfied that any concerns arise from ill health rather than misconduct or incapability. In that situation the case manager must then consider whether the practitioner should:

- Be removed from duties if the person is not on sickness absence.
- Have his/her practice restricted, for instance, by removing certain duties.
- Be excluded.
- Simply continue sickness absence, but on the strict basis that the situation will be reviewed in the event that the practitioner indicates he/she is fit to return to work. At that point the case manager should seek further advice from Occupational Health on this issue. If the practitioner is insisting on returning to work in circumstances where Occupational Health says he/she is not fit to do so and there could be a risk to patient safety, then the case manager is entitled to consider exclusion or a restriction of practice as appropriate.
- If sickness absence continues it will dealt with under the Trust's sickness absence procedure and paragraph 2 of this procedure with due regard to the Equality Act 2010, if applicable.

4. Where issues of ill health arise during the application of the procedures for addressing capability or conduct

This section addresses circumstances where:

- Part way through a conduct or capability procedure the practitioner argues any concerns were caused by his/her ill health.
- Where the practitioner says a capability or conduct procedure should be delayed because of his/her ill health.
- Where a practitioner says conduct or capability procedures should be halted and purely handled as a health issue.

4.1 Practitioner putting that concerns are caused solely by ill health

In this situation the first step for the case manager is to obtain an Occupational Health report as set out above. If there is a dispute as to whether or not the practitioner's ill health caused the concerns or Occupational Health has been unable to offer a view on this, then the case manager may refer the practitioner to a specialist for a further opinion. If Occupational Health advice is clear, the case manager is entitled to act on the basis of that advice. He/she is also entitled to act on the basis of the specialist's advice (if obtained) if that conflicts with the practitioner's medical advice.
The case manager should seek advice from the NCAS on this issue. Where there is such dispute the case manager will write to the practitioner within 5 working days of receiving the specialist's and Occupational Health's advice setting out his/her decision. The case manager should confirm whether the matter will be dealt with as an ill health issue or under the capability or conduct procedure as appropriate. If the case manager determines that the issue is an ill health issue, he/she should follow the procedure set out at paragraph 3 above. If he decides the issue is a matter of conduct or capability, then that process will continue subject to what is set out below.

4.2 Delaying a conduct or capability procedure due to a practitioner's ill health

Where a Practitioner seeks the delay of an investigation, conduct or capability hearing, he/she must, without delay, seek such delay in writing providing supporting medical evidence. If no such written reasons or medical evidence is provided, the case manager is entitled to take this into account in deciding whether to delay the process. Any decision whether to delay the process is the case manager's.

Where a practitioner says that he/she is unfit to attend a conduct or capability hearing or take part in an investigation, the case manager should refer the practitioner to Occupational Health promptly and in any event within 4 weeks of the sickness absence starting to consider:

- The practitioner's general state of health at that point.
- The prognosis as to when the practitioner's health might improve.
- The practitioner's ability to give instructions to his trade or defence union representative to defend his/her position.
- The practitioner's ability to participate in the conduct or capability hearing.
- If the assessment is that the practitioner is unfit to give instructions or take part in the hearing, provide an opinion as to when he/she may be able to.
- Provide an opinion on the likely impact of the procedure remaining on hold in the long term. Is there any benefit to the practitioner's health in moving forward with the procedure at a certain point?
- Asking for a written report addressing these issues.

The case manager should discuss any decisions as to whether to delay the proceedings with the NCAS. If, having taken all matters into account, the case manager is satisfied that circumstances require a delay to be lifted, he/she must write to the practitioner explaining this fact and giving reasons for such decision. If notice is given of a conduct or capability hearing, the case manager should explain that the practitioner is entitled to attend this hearing or ask a representative to attend in his/her absence and/or present written representations. Alternatively, the case manager may decide proceedings should re-start at a specified date.

Once an Occupational Health report has been received, the case manager should convene a meeting with the practitioner, his/her representative and the Director or Head of Human Resources to consider the way forward. The case manager shall take into account the practitioner's views, but it remains the case manager's responsibility to ensure the process is effectively handled. The case manager may conclude that:

- A delay for a certain period of time is appropriate but the situation should then be reviewed at that point.

- A delay is appropriate for a certain period at which point the practitioner should be referred to Occupational Health once more for a further assessment at which point the situation will be re-assessed.

- The Occupational Health advice is clear that an impasse has been reached and that it would actually be beneficial to the practitioner to continue the process at a certain point. In doing so, the case manager is entitled to take into account the risk of memories fading if there is a lengthy delay in the proceedings.

The practitioner must reasonably co-operate with Occupational Health. If he/she does not do so, for instance, by unreasonably refusing to accept a referral to Occupational Health, then he/she may be subject to separate disciplinary actions. The case manager will further be entitled to take such issue into account in deciding whether to delay a conduct or capability hearing or investigation.

4.2 Practitioner request to terminate or modify conduct or capability proceedings

In the event that a practitioner requests that the scope of proceedings be modified or terminated, the case manager should refer the practitioner to Occupational Health within 4 weeks of such request. Again, the Occupational Health Advisor should be asked specific questions as to the practitioner's state of health, ability to take part in the process, and the implications of the modification or termination sought on the practitioner's health. When a report is received from Occupational Health, the case manager should consider this report alongside any representations that the practitioner makes. The case manager should also take into account:

- Evidence suggesting there is a risk to patient safety.
- Evidence suggesting there is a risk to other staff.
- The seriousness of the concerns.
- Evidence of any serious dysfunction in the operation of the service in which the practitioner works.

The case manager is entitled to weigh these factors in the balance in determining whether to modify or terminate conduct or capability proceedings. The case manager should discuss this matter with the NCAS. Having done so, the case manager must write to the practitioner setting out his decision as to whether to modify or terminate the procedure and giving reasons for it. If the case manager determines it is inappropriate to modify or terminate the procedure, he/she should outline what next steps will be taken in the process. These might include:

- A further Occupational Health assessment.
- A delay in the proceedings until a specified date.
- Where the case manager considers the circumstances justify it, setting a date for a conduct or capability hearing.

5. Practitioners in training grades where ill health issues arise

Where a concern involves a training grade practitioner, the Trust shall seek advice from the Post Graduate Dean in each of the situations set out above.

6. Reporting Practitioners with health concerns to Regulatory Bodies

If a practitioner's ill health makes them a danger to patients and he/she does not recognise this, or is not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and is potentially justifiable. Furthermore, the NCAS and GMC or GDC must be informed irrespective of whether or not the practitioner has retired on ill health grounds.

4.0 Statement of evidence/references

External weblink references:
Maintaining High Professional Standards in the Modern NHS
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4103344.pdf

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
1	N/A		None – new policy

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Director of workforce	Executive lead -Workforce	N/A	N/A	Policy originating from workforce team Contents page to be populated, policy needs to be numbered throughout for ease of reference.	Yes
Medical director	Executive lead – Medical profession	11th July 2016	29th September 2016	Section 4, Conduct, omitted.	Yes
Joint Local Negotiating Committee (JLNC)	Staff-side Negotiation and consultation	9th November 2016	9th November 2016	Reissue policy with the above amendments for review and comment	Yes
Medical director	Executive lead – Medical profession	30th December 2016	8th December 2016	Formatting and page layout, Additions to role of case manager so as to cover OH referral	Yes
BMA and JLNC chair	Trade union; negotiation and consultation			Clarification of part 1, paras 6.2, 7.3 Additions to part 2: 6.3 to include rights of representation, 7.2 to mirror DH MHPS and 17 to inform a practitioner when GMC/GDC referral is made Part 5; para 4.1 – amendment to title of section Appendix F, bullet point 3 – clarification of additional evidence that can be considered by a case investigator	Yes
Clinical board	Medical & dental profession & performance	12th December 2016	14th December 2016	Reassurance that national framework is adhered to as a minimum.	Yes

				Further comments requested by 19th December 2016	
Management board	Formal trust decision making forum	21st December 2016	21st December 2016	Reference to responsible officer role Divisional directors can act as case managers Case manager in conjuction with medical director, workforce director and CEO can appoint case investigators Clarity on consultation with NCAS Role of Local Negotiating Committee Reference to trust sickness absence policy to 'ill health' section.	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Monitoring of cases being managed under this policy	Workforce Information Report	Director of workforce	Quarterly	Workforce and Development Assurance Committee
Monitoring of compliance with exclusion process	Board report	Director of workforce	Monthly	Trust Board

5.4 Equality Impact Assessment

This document has been assessed using the Trust's Equality Impact Assessment Screening Tool. No detailed action plan is required. Any ad-hoc incident which highlights a potential problem will be addressed by the monitoring committee.

Impact	Age	Disability	Sex (gender)	Gender Reassignment	Race	Religion or Belief	Sexual orientation	Marital Status	Pregnancy & Maternity
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	N	N	N	N	N	N	N	N	N
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	N	N	N	N	N	N	N	N	N

APPENDIX A: Definitions

"Case Manager" is the person who has responsibility for overseeing investigations into concerns about a practitioner. His/her duties are to:

- On first hearing about these concerns needing to decide whether they should be formally investigated.
- Notify the practitioner in writing of such investigation.
- Consider (usually with the director of workforce and chief executive) whether to immediately restrict a practitioner's duties or exclude him/her from work or take some other form of protective action.
- The case manager shall also form a view as to whether an occupational health referral is required and make the referral or arrange for it to be made, as appropriate.
- Upon receipt of the case investigator's report consider whether a formal procedure should be started (for instance a disciplinary hearing). At this stage, he/she will also consider whether any immediate restrictions or exclusion should be continued.
- Review any exclusion and determine after careful thought whether it should be continued.
- Prepare reports on each exclusion before the end of each four week exclusion period.
- Liaise with and seek the advice of the NCAS as set out in this policy.

"**Case Investigator"** is the person who is responsible for carrying out a formal investigation into concern(s) about a practitioner. He/she:

- Must carry out a proper and thorough investigation into the concerns.
- Involve an appropriately qualified clinician to investigate clinical concerns if he/she does not have such qualifications.
- Ensure that appropriate witnesses are interviewed and evidence reviewed.
- Ensure that any evidence gathered is carefully and accurately documented.
- Keep a written record of the investigation, the conclusions reached and the course of action

agreed with the Medical and HR directors.

- Meet with the practitioner in question to understand the practitioner's case.
- Prepare a report at the conclusion of the investigation providing the case manager with enough information to decide how to take it forward.
- Provide updates and assistance to the designated Board member on the progress of the investigation.
- Provide factual information to assist the case manager in his/her review of any exclusion.

"Designated Board Member" is a non-executive director of the Trust who ensures that the processes set out in these guidelines are being followed but does not make decisions on any issues such as whether to exclude from work. He/she:

- Ensures that the investigation is being carried out promptly and in accordance with these guidelines.
- Acts as a point of contact for the practitioner, making him/herself available after due notice if the practitioner has significant concerns about the progress of the investigation or any exclusion from work.

"Clinical Advisor" is the person who provides clinical advice and guidance to the case investigator if relevant where clinical issues arise (in relation to capability or professional misconduct). He/she will have appropriate specialist skills to advise. Where no such person is available or is precluded from advising (for instance if he/she raises the concerns) the Trust will seek to identify a person outside its employment to advise.

"Responsible officer" All doctors relate to a single responsible officer[1]. The Medical Profession (Responsible Officers) Regulations 2010 and The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 place a number of duties on responsible officers and designated bodies in relation to responding to concerns. The legislation makes it clear that the designated body in which the responsible officer is based has a statutory obligation to support the responsible officer in discharging their duties, including providing the appropriate level of resource to support them in this.

[1] The responsible officer may delegate particular roles and functions covered by the regulations to others. For the purposes of this document, the term responsible officer should be interpreted as including those acting with appropriate delegated authority.

APPENDIX B: Authorisations

Set out below are lists of those authorised to fulfil certain roles under these guidelines. The Trust reserves the right to add to or remove from these lists as it considers necessary.

Case managers

The following are authorised by the Trust to act as case managers: the medical director (or acting medical director), an appropriate divisional director appointed by the medical director (in a case not involving a Consultant) or any medical director or divisional director not employed by the Trust who has been requested to undertake this role by the chief executive of the Trust, or medical director.

Case investigators

The following are authorised by the Trust to act as case investigators: clinical and non-clinical directors and general managers.

Designated members

The Trust's non-executive directors are authorised by the Trust to act as designated members in line with the definitions outlined within this policy.

Employees with the power to exclude doctors from work or restrict their practice

The following are authorised to exclude or restrict practice: the (acting) chief executive, the (acting) medical director, the (acting) director of workforce and divisional directors (for practitioners below the grade of consultant).

APPENDIX C: Checklist on excluding/restricting practice when concerns first arise

WHO DISCUSSED THIS?	**[Insert names]**
WHEN?	**[Insert date]**
SUMMARISE THE AREAS OF CONCERN	[**Insert summary]**
HAS THE NCAS BEEN CONSULTED?	YES/NO. **[Give name of NCAS officer spoken to if applicable and when discussion took place]**
IF SO, WHAT WAS ITS ADVICE?	**[Insert summary]**
HAS AN NCAS ASSESSMENT BEEN CONSIDERED? IS IT AN APPROPRIATE ACTION? IF NOT, WHY NOT?	YES/NO. **[Insert summary answer]**
HAS SUPERVISION BY CLINICAL MEDICAL DIRECTOR BEEN CONSIDERED? IS IT AN APPROPRIATE ACTION? IF NOT, WHY NOT?	YES/NO. **[Insert summary answer]**
HAS RESTRICTING THE PRACTITIONER'S CLINICAL DUTIES BEEN CONSIDERED? IS IT AN APPROPRIATE ACTON? IF NOT, WHY NOT?	YES/NO. **[Insert summary answer]**
HAS RESTRICTING ACTIVITIES TO NON-CLINICAL DUTIES AND/OR RE-TRAINING BEEN CONSIDERED? IS IT AN APPROPRIATE ACTION? IF NOT, WHY NOT?	YES/NO. **[Insert summary answer]**
IS IMMEDIATE EXCLUSION NECESSARY? IF SO, OUTLINE REASON FOR THIS (E.G. A SERIOUS CLINICAL CONCERN HAS ARISEN AND THE PRACTITIONER'S PRESENCE IS LIKELY TO HINDER INVESTIGATION) AND BASIS FOR SUCH CONCLUSION	YES/NO. **[Insert reasoning]**
WHAT ARRANGEMENTS HAVE BEEN AGREED TO INFORM THE PRACTITIONER?	**[Insert details]**
	Signed……

	Printed name…… Designation……... Date……

APPENDIX D: Template letter to send to practitioner being immediately excluded/restricted from practice

STRICTLY PRIVATE & CONFIDENTIAL
ADDRESSEE ONLY
[Insert name and address]

[Insert date]

Dear **[insert name of practitioner]**

I am writing to inform you that serious concerns have been raised concerning your **conduct/ professional competence/health] [delete / add to as appropriate]**. These concerns are that:

[Set out details of the concerns]

In accordance with Department of Health Guidance and Trust procedure, I will be the case manager dealing with your case. In the circumstances, I have discussed this case with **[insert names]**. I have also consulted with the NCAS.

The above concerns are very serious. They need to be investigated further. I have therefore appointed **[insert name]** to investigate these concerns with all proper speed. It is anticipated that **[insert name]** will complete his/her investigation by **[insert date four weeks from date of letter]**. I will then endeavour to write to you within five days of the completion of the investigation to provide you with a copy of the investigatory report.

In the meantime I and **[insert names]** have considered and consulted with the NCAS over the following alternatives:

- Your clinical duties being carried out under the supervision of the **[medical/divisional]** director **[delete as appropriate]**

- A restriction of your clinical duties pending the investigation or any formal procedure that may follow if considered necessary

- Asking you to cease clinical duties pending completion of the investigation/any procedures flowing from it

- An NCAS assessment

- Immediately excluding you from work for **[insert period up to a maximum of two weeks]**

After the most careful consideration, I have decided that it is appropriate to **[insert conclusion]**. I did not consider the other alternatives I have set out appropriate because:

[Set out reasons for rejecting other options.]

I considered that **[insert option decided upon]** was appropriate because:

[Insert reasons for your choice of option.]

This information must be treated in the strictest confidence by you as it will be by the Trust. You are of course free to discuss it with your professional Advisor/defence organisation/representative. Otherwise you should not discuss it further.

[Insert if excluding from work.]

Exclusion from work is a neutral act. It does not denote guilt or any suggestion of guilt.

During the period of exclusion you

[either]

may only attend the Trust's premises for audit meetings, research purposes, and study or continuing professional development. Obviously there is no limitation on you attending Trust premises to receive medical treatment.

[Or]

you should not attend the Trust's premises unless specifically invited to do so by me or **[insert name of case investigator]**. Of course this does not affect your ability to come to receive medical treatment.

During your exclusion from work you will continue to receive your full salary and benefits. You must remain ready and available to work. You must seek permission for annual and study leave from me, in the normal way. During your working hours you must be available and contactable to provide information to **[insert name of case investigator]**. If you are unavailable for work during your exclusion, this may result in the Trust stopping your pay.

[Applies where restriction on practice is agreed with the practitioner]

Please signify your agreement to the restrictions on your practice by signing and returning the enclosed copy of this letter. If you do not agree to abide by these restrictions, the Trust reserves the right to review this situation and any actions it may need to take in order to safeguard patient interests.

[Applicable in all cases]

[Insert name], a non-executive director of the Trust is designated to ensure that your case is dealt with fairly and promptly.

[Applicable in exclusion cases]

[You may make representations to **[insert name]** on your exclusion from work.

A meeting has been scheduled to meet with myself on **(date)** at **(time)** in **(location**) to discuss the progress in the case. You will be entitled to be accompanied at this meeting by a trade union/staff side representative, or lawyer instructed by them, a work colleague not likely to be called as a witness in the case or a friend.

If you have any questions, please contact me.

Yours sincerely

[Insert name of case manager]

APPENDIX E: Case manager's initial assessment report

General Principles

This Guidance relates to when initial concerns have been raised with the case manager. The case manager should decide how such concerns should be taken forward in accordance with Part 1.

If an immediate decision on how to deal with the concerns is unnecessary, then the case manager should set out their decision in an Initial Assessment Report, in accordance with the Guidance below. Where immediate action is necessary and it is simply not practicable to document the decision beforehand, then it would be best practice to produce an Initial Assessment Report, after the event so that there is a record of the reasons for the decision.

The Initial Assessment Report is not intended to be and cannot be a thorough investigation of all the issues arising from the concern. The case manager is only concerned in investigating the concern to the extent that it is necessary to make a preliminary decision on how matters should be taken forward.

The case manager's preliminary decision on how the matter should be taken forward, as set out in the Initial Assessment Report, should not in any way affect the case investigator's conclusions (if a case investigator is later appointed) or the fact that the case manager may subsequently decide that it is more appropriate to take matters forward in another way. For example, a case manager may believe in their initial assessment that a serious concern has arisen which requires investigation. However, following the investigation, the case manager may decide that it is unnecessary to take any further action.

The Report

The Initial Assessment Report should usually include the following:

a clear statement of what the concern(s) is/are;

- an explanation of any steps the case manager has taken to clarify the concern(s). It should also identify any evidence or witnesses that have been identified by the case manager. Any evidence identified by the case manager as part of this initial assessment should be secured in a safe place and passed to the case investigator if there is a formal investigation subsequently;

- any advice received from NCAS should be noted together with a record of the name of the NCAS officer and when the advice was given;

- the case manager's view on how the matter should be dealt with in accordance with paragraphs 6 - 7, Part 1 and the reasons for this should be set out. For example, the case manager may decide that no serious concerns have arisen and the matter may be dealt with by counselling. By way of further example, the case manager may decide that a formal investigation is necessary before he or she can decide upon the appropriate procedure to apply;

- the case manager should identify what the next steps will be and who will undertake these. For example, if concerns relate to a practitioner's health, it may be necessary to make a referral to the Occupational Health Department in accordance with Part 6. Another example is where the concern is not considered serious, the case manager may believe that the practitioner's line manager should counsel the practitioner to avoid a re-occurrence of the issue;

The Initial Assessment Report should be signed and dated.

The initial Assessment Report should not be lengthy.

APPENDIX F: Terms of reference for case investigator

Where a case manager decides that a formal investigation is necessary, Terms of Reference should normally be produced in order to focus the investigation.

The Terms of Reference should usually include the following:

- identification of the case manager, the case investigator and the Designated Member;
- a clear statement of the concerns which are the subject of the investigation and the case investigator should be requested to investigate these concerns and report on them;
- any evidence collated by the case manager should be appended to the Terms of Reference and any relevant witnesses should be identified. It should however be stressed that the case investigator's investigation is not limited to considering this evidence alone and it is entirely for the case investigator, at his or her discretion, to determine how best to investigate the concerns set out in the Terms of Reference. This may take the form of information supplied by the practitioner, witnesses or the case manager, as appropriate and relevant to the Terms of Reference;
- identification of any Human Resources Advisor and/or a specialist clinician working in the same area as the practitioner who will assist the case investigator;
- the date by which the investigation should be completed or by which a progress report should be provided; and
- the date by which the case investigator's report should be presented to the case manager.

The Terms of Reference should be signed and dated by the case manager

Checklist for policy and guidelines documentation

By submitting a document for review/approval you are confirming that the document has been checked against the checklist below to ensure it meets the Trust standards for producing Trust Documentation (for support please contact your Governance Facilitator/Patient Safety Lead.

Check	Tick
Latest template	☐
Fonts should be arial 14 for headers 12 for main body	☐
Clear Title (and saved with this title)	☐
Authors Job title:	☐
Authors Division:	☐
Department/Groups this document applies to:	☐
Approval Group/approved by:	☐
Date of approval:	☐
Review date:	☐
Approval group (according to policy requirements):	☐
Last review date:	☐
Unique Identifier: if known (new documents will be assigned at publication)	☐
Status: Approved	☐
Version numbers are the same throughout document	☐
Scope: Who will use this document?	☐
To be read in conjunction with the following documents:	☐
Latest CQC fundamental standards referenced:Trust intranet page with fundamental standards	☐
Footers completed to match main page : (on all pages)	☐
References are updated (contact the library (Lynda Plant 3077) for help if required)	☐
Consultation history includes key stakeholders required to embed document. Pharmacy are consulted if the document contains medication	☐
Audit and monitoring criteria is completed and clear (where possible reference the relevant section of the policy)	☐
Draft watermark is removed	☐
Include full & correct consultation history	☐
Dissemination should be clear	☐
Check relevant hyperlinks work	☐

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