

**The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Employment Policies and Procedures**

**Capability Procedure to address concerns regarding competence of medical
and dental staff**

Effective: November 2010

Review: June 2013

1. Introduction

- 1.1 The aim of the Policy and Procedure is to ensure consistent and fair treatment and to assist doctors and dentists who are not achieving a satisfactory level of performance in the post to which they were appointed.
- 1.2 If it is considered that failure to achieve the required standard of job performance is because of carelessness, lack of effort or negligence by the individual, then the matter will be dealt with under the Trust's Disciplinary Policy as misconduct.
- 1.3 Concerns about capability should not be confused with disability. If an individual becomes disabled it is important to ensure every reasonable effort will be made to retain them in their original post or reemploy them to a suitable alternative post in line with the Trust's obligations within the Disability Discrimination Act.
- 1.4 This procedure is internal a framework and the Trust reserves the right to adapt it to suit the needs of each situation. It may not be appropriate to follow each stage of the steps in turn or in the time frame proposed. The Trust will take each individual case on its own merits in determining the stage or manner of dealing with concerns relating to job performance.

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Maintaining High Professional Standards in the Modern NHS

I. ACTION WHEN A CONCERN ARISES

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I. Action When a Concern Arises

Introduction

1. The management of performance is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to formal procedures.

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

- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff
 - Review of performance against job plans, annual appraisal, revalidation
 - Monitoring of data on performance and quality of care
 - Clinical governance, clinical audit and other quality improvement activities
 - Complaints about care by patients or relatives of patients
 - Information from the regulatory bodies
 - Litigation following allegations of negligence
 - Information from the police or coroner
 - Court judgements
2. Unfounded and malicious allegations can cause lasting damage to a doctor's reputation and career prospects. Therefore all allegations, including those made by relatives of patients, or concerns raised by colleagues, must be proportionately investigated to verify the facts.

Framework for NHS Procedures

3. Concerns about the capability of doctors and dentists in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.
4. All serious concerns must be registered with the Chief Executive or Medical Director who must ensure that a case manager is appointed and must designate a non-executive member of the Board "the designated member" to oversee the case and ensure that momentum is maintained.

All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director will need to work in consultation with HR to decide the appropriate course of action in each case. The Medical Director will either act as the case manager or may delegate this role to a member of the Medical Directors Team to oversee the case on his or her behalf. The Medical Director is responsible for appointing a case investigator.

Protecting the public

5. When serious concerns are raised about a practitioner, the Trust must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Part II of this framework sets out the procedures for this action.
6. The duty to protect patients is paramount. At any point in the process where the case manager has reached the clear judgement that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the regulatory body, whether or not the case has been referred to the NCAS* (National Clinical Assessment Service). Consideration should also be given to whether the issue of an alert letter should be requested.

[*The GMC (General medical council) or GDC (General dental council)] may discuss with [the Trust] whether any immediate action is needed by the GMC/GDC but it is the Trust's decision whether or not to continue with its own internal procedures.

Involving the NCAS

7. At any stage of the handling of a case consideration should be given to the involvement of the NCAS.

Understanding the issue and investigation

8. The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with HR and the Medical Director. The NCAS can provide a sounding board for the case manager's first thoughts.

However, it is preferable that the first approach to the NCAS should be made by the Medical Director.

9. The first stage of any NCAS involvement in a case is exploratory- an opportunity for local managers to discuss the problem with an impartial outsider, to look afresh at a problem, see new ways of tackling it themselves, possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than the NCAS.
10. The case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. In less serious cases where an informal route is chosen the NCAS can still be involved until the problem is resolved. This can include the NCAS undertaking a formal clinical performance assessment when the doctor, the Trust and the NCAS agree that this could be helpful in identifying the underlying cause of the

problem and possible remedial steps. If the NCAS is asked to undertake an assessment of the doctor's practice, the outcome of a local investigation may be made available to inform the NCAS's work.

11. Where it is decided that a more formal route needs to be followed the Medical Director must appoint an appropriately experienced or trained person as case investigator. The seniority of the case investigator will differ depending on the grade of practitioner involved in the allegation.
12. The case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The case investigator:
 - should if appropriate formally involve a senior member of the medical or dental staff* where a question of clinical judgement is raised during the investigation process.
 - must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but the disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered.
 - must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene a disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report.
 - must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director, in consultation with HR.
 - must assist the designated Board member in reviewing the progress of the case.

The case investigator does not make the decision on what action should be taken nor whether the employee should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.

*Where no other suitable senior doctor or dentist is employed by the Trust a senior doctor or dentist from another NHS body may be involved.

13. The practitioner concerned must be informed in writing by the case manager, as soon as practicable after it has been decided, that an investigation is to be undertaken, the name of the case investigator and made aware of the allegations or concerns that have been raised. The practitioner should be given the opportunity to see any relevant correspondence relating to the case together with a list of the people that the case investigator intends or wishes to interview. The practitioner must also be afforded the opportunity to put their

view of events to the case investigator and given the opportunity to be accompanied.

14. At any stage of this process - or subsequent disciplinary action – the practitioner may be accompanied in any interview or hearing by a companion. The companion may be another employee of the Trust; an official or lay representative of the British Medical Association, British Dental Association or defence organisation. It would be unusual for the companion to be legally qualified but may in serious circumstances be permitted if the Trust in consultation with the relevant Professional Society or Defence Organisation agree, such consent not to be (unreasonably) refused. The Trust reserves the right in such circumstances to appoint its own legal advisors to assist the Trust.

Whilst the Trust acknowledges this to be a process with potential legal consequences, it is not intended to be excessively legalistic in approach.

15. The case investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter
16. If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider whether an independent practitioner from another NHS body might be invited to assist.
17. The case investigator should use their best endeavours to complete the investigation within 4 weeks of appointment and submit their report to the case manager within a further 5 working days. The report of the investigation should give the case manager sufficient information to make a decision whether:
 - there is a case of misconduct that should be determined under the Trust’s disciplinary procedures;
 - there are concerns about the practitioner's health that should be considered by the NHS body's occupational health service;
 - there are concerns about the practitioner's performance that should be further explored by the National Clinical Assessment Service;
 - restrictions on practice or exclusion from work should be considered;
 - there are serious concerns that should be referred to the GMC or GDC;• the matter should be put before a capability panel;
 - No further action is needed.

Involvement of the NCAS following local investigation

18. Medical under performance can be due to various reasons. These may occur in isolation or in a combination. The NCAS's processes are aimed at addressing all of these, particularly if local action has not been able to take matters forward successfully. The NCAS's methods of working therefore assume commitment

by all parties to take part constructively in a referral to the NCAS. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.

19. Where an employing body is considering excluding a doctor or dentist whether or not his or her performance is under discussion with the NCAS, it is important for the NCAS to know of this at an early stage, so that alternatives to exclusion can be considered. Procedures for exclusion are covered in part II of the framework. It is particularly desirable to find an alternative when the NCAS is likely to be involved, because it is much more difficult to assess a doctor who is excluded from practice than one who is working.
20. A practitioner undergoing assessment by the NCAS must cooperate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the NCAS assessment is complete*. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncaa.nhs.uk/services.

*Under circular HSC 2002/011, Annex 1, paragraph 3, "A doctor undergoing assessment by the NCAS must give a binding undertaking not to practise in the NHS or private sector other than in their main place of NHS employment until the assessment process is complete."

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

Confidentiality

22. The parties must maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Trust should only confirm that an investigation or disciplinary hearing is underway, if requested to do so.
23. Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter under investigation. The Trust needs to take into account the guiding principles of the Data Protection Act.

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II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

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Restriction of practice and exclusion from work

Introduction

1. This part of the framework replaces the guidance in HSG (94)49*. Under the Restriction of Practice and Exclusion from Work Directions 2003 ("the directions"), NHS employers must incorporate these principles and procedures within their local procedures.

*HSG(94)49- Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff. Department of Health, 1994.

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

Managing the risk to patients

4. When serious concerns are raised about a practitioner, the Trust must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the postgraduate dean should be involved as soon as possible.
5. Exclusion of clinical staff from the workplace is a temporary expedient. Exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work should be reserved for only the most exceptional circumstances.
6. The purpose of exclusion is:
 - to protect the interests of patients or other staff; and/or

- to assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken. The degree of action must depend on the nature and seriousness on the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

7. Alternative ways to manage risks, avoiding exclusion, include:

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

8. In suitable cases relating to the capability of a practitioner, consideration should be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach may be sought from the National Clinical Assessment Authority (NCAS). If the nature of the problem and a workable remedy cannot be determined in this way, the case manager may seek to agree with the practitioner to refer the case to the NCAS, which can assess the problem in more depth and give advice on any action necessary.

THE EXCLUSION PROCESS

9. The Trust cannot require the exclusion of a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed.

Roles of officers

10. The decision to exclude a member of staff is taken by the case manager. In all cases the case manager will first discuss the issue with the Medical Director or, in his or her absence, the on-call member of the Medical Director's team. Whenever possible the case manager will also consult with the following parties before the decision is taken:

- Chief Executives
- Human Resources
- Designated Board Member
- NCAS

11. In rare cases where immediate exclusion is required the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.
12. The case manager will review the need for exclusion and make reports on progress to the Chief Executive and designated Board member as required.

Role of designated Board member

13. Representations may be made to the designated Board member in regard to exclusion, or investigation of a case. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights (which, broadly speaking, sets out the framework of the rights to a fair trial).

Immediate exclusion

14. An immediate time limited exclusion may be necessary for the purposes identified in paragraph 6 above following:
 - a critical incident when serious allegations have been made; or
 - there has been a break down in relationships between a colleague and the rest of the team; or
 - the presence of the practitioner is likely to hinder the investigation.

Such an exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to contact the NCAS for advice and to convene a case conference.

The manager making the exclusion must explain to the practitioner concerned why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date up to a maximum of two weeks away at which the practitioner should return to the workplace for a further meeting. The case manager must advise the practitioner of their rights, including rights of representation.

Formal exclusion

15. In normal circumstances a more formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. The NCAS should be consulted where formal exclusion is being considered. If a case investigator has been appointed he or she should endeavour to produce a preliminary oral or written report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the case manager to decide on the next steps as appropriate.

16. The report should provide sufficient information for a decision to be made as to whether:
 - the allegation appears unfounded; or
 - there is a misconduct issue; or
 - there is a concern about the practitioner's capability; or
 - the complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be inquired into.
17. Formal exclusion of one or more clinicians must only be used where a. there is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:
 - allegations of misconduct,
 - concerns about serious dysfunctions in the operation of a clinical service,
 - concerns about lack of capability or poor performance of sufficient, seriousness that it is warranted to protect patients;

Or

 - b) the presence of the practitioner in the workplace is likely to hinder the investigation.
18. Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.
19. When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction).
20. The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 23, and the need to remain available for work paragraph 24) and that a full investigation or what other action will follow. The practitioner and their companion should be advised that they may make representations about the exclusion to the designated board member at any time after receipt of the letter confirming the exclusion.
21. In cases when disciplinary procedures are being contemplated, exclusion may be extended for four-week renewable periods until the completion of disciplinary procedures if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review. The exclusion should usually be lifted and the practitioner allowed back to work, with or

without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

22. If the case manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case should be referred to the NCAS for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period the principle of four-week "renewability" must be adhered to.
23. If at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion, and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

Exclusion from premises

24. Practitioners should not be automatically barred from the premises upon exclusion from work. Case managers must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where the practitioner may be a serious potential danger to patients or other staff. In other circumstances, however, there may be no reason to exclude the practitioner from the premises. The practitioner may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

Keeping in contact and availability for work

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

Informing other organisations

27. In cases where there is concern that the practitioner may be a danger to patients, the Trust has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer*.

*NHS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts. A draft model protocol is available from the Department of Health.

28. Where the case manager believes that the practitioner is practising in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, he or she should contact the professional regulatory body and the Director of Public Health or Medical Director of the Strategic Health Authority to consider the issue of an alert letter.

Informal exclusion

29. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' should be avoided.

KEEPING EXCLUSIONS UNDER REVIEW

Informing the Chief Executive

32. The Chief Executive must be informed about exclusion at the earliest opportunity. The CEO has a responsibility to ensure that the Trusts internal procedures are being followed and should, therefore:
- require a summary of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible;
 - receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended.

Regular review

33. The case manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive * and Medical Director (unless he or she is the case manager).

This report is advisory and it would be for the case manager to decide on the next steps as appropriate. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

34. Each review is a formal matter and must be documented as such. The practitioner should be sent written notification on each occasion.

6 months review

If the exclusion has been extended over six months,

- A position report must be made by the Chief Executive to the Board and SHA indicating:
 - the reason for continuing the exclusion;
 - anticipated time scale for completing the process;
 - actual and anticipated costs of the exclusion.
 - The SHA will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can offer to the Board.
35. Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

The role of the SHA in monitoring exclusions

36. When the SHA is notified of an exclusion, it should ensure that the NCAS has also been notified.
37. On notification the Chief Executive (or a nominated officer) must inform the SHA of what action is proposed to resolve the situation. This should include dates for hearings or give reasons for the delay. Where retraining or other rehabilitation action is proposed, the reason for continued exclusion must be given.

The role of the Board and designated member

38. The Board has a responsibility for ensuring that these procedures are established and followed. It is also responsible for ensuring the proper corporate governance of the organisation, and for this purpose periodic reports must be made to the Board under these procedures.

40. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review.
41. The Board is responsible for designating one of its non-executive members as a "designated Board member" under these procedures. The designated Board member is the person who oversees the case manager and investigating manager during the investigation process and maintains momentum of the process.
42. This member's responsibilities include:
 - receiving reports and reviewing the continued exclusion from work of the practitioner;
 - considering any representations from the practitioner about his or her exclusion; considering any representations about the investigation;

RETURN TO WORK

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

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III CONDUCT HEARINGS AND DISCIPLINARY ACTION

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III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY

PROCEDURES

Introduction

1. Misconduct matters for doctors and dentists, as for all other staff groups, are dealt with under the Trusts procedures covering other staff charged with similar matters. The practitioner is referred to the Trust's Disciplinary Policy and Procedure.
2. NHS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts.
3. Examples of misconduct will vary greatly. The Trusts disciplinary rules set out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Similarly the ACAS Code of Practice provides a non-exhaustive list of examples. Acts of misconduct may be simple and readily recognized or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.
4. Any allegation of misconduct against a doctor or dentist in recognized training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset.
5. Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.
6. Each case must be investigated, but as a general rule no employee should be dismissed for a first offence, unless it is one of gross misconduct.
7. It is for the Trust to decide upon the most appropriate way forward, having consulted if necessary their own employment law specialist and/or NCAS. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively or in addition he or she may make representations to the designated board member

ALLEGATIONS OF CRIMINAL ACTS

Action when investigations identify possible criminal acts

10. Where the Trusts investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted. In all cases the Trust reserves the right to conduct its own procedures notwithstanding any police involvement.

Cases where criminal charges are brought not connected with an investigation by the Trust

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

Dropping of charges or no court conviction

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

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IV. PROCEDURES FOR DEALING WITH ISSUES OF CAPABILITY

Introduction & General Principles

1. The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organisational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.
2. The National Patient Safety Agency (NPSA) was established to coordinate the efforts of all those involved in healthcare to learn from adverse incidents occurring within the NHS. In particular, the NPSA aims to facilitate the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses in a climate free from fear of personal reprimand, where the sharing of experience helps others to learn lessons and in turn improve patient safety.
3. However, there will be occasions where the Trust considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of skills, aptitude, health or knowledge. These are described as capability issues. Matters that should be described and dealt with as misconduct issues are covered in the Trust's Disciplinary Policy Procedure.
4. Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from the National Clinical Assessment Service (NCAS) will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, **the matter should be referred to the NCAS before the matter can be considered by a capability panel** (unless the practitioner refuses to have his or her case referred).
5. Matters which may fall under the capability procedures include:

Some examples of concerns about capability

- out of date clinical practice;
- clinical practice that puts patients at risk arising from a lack of knowledge, aptitude, experience or skills;
- inability to communicate effectively;
- inappropriate delegation of clinical responsibility;
- inadequate supervision of delegated clinical tasks;

- ineffective clinical team working skills;
6. Wherever possible, the Trust should aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. The NCAS has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and should be consulted. A web based toolkit has been developed and is available at: www.ncas.nhs.uk/toolkit.
 7. Any concerns about capability relating to a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor, with close involvement of the postgraduate dean from the outset.

How to proceed where conduct and capability issues involved

8. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they can be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the Trust to decide on the most appropriate way forward having consulted with an NCAS adviser and their own employment law specialist.

Duties of Employers

9. The procedures set out below are designed to cover issues where a doctor's or dentist's capability to practise is in question (5). Prior to instigating these procedures, the Trust should consider the scope for resolving the issue through counselling or retraining and should take advice from the NCAS.
10. Capability may be affected by ill health. Arrangements for handling concerns about a practitioner's health are described in part V of this framework. The Trust must follow its own procedure for dealing with ill health
- ..
11. Trusts must ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds.
12. The Trust will ensure that managers and case investigators receive appropriate and effective training in the operation of capability procedures. Those undertaking investigations or sitting on capability or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members must have completed before they can take a part in these proceedings.

CAPABILITY PROCEDURE

The pre-hearing process

13. When a report of the Trust investigation (as in Part I6) has been received, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.
14. The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. The case manager will need to consider urgently:
 - whether action under Part II of the framework is necessary to exclude the practitioner; or
 - to place temporary restrictions on their clinical duties.

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

15. If an assessment plan is pursued, the NCAS will assist the employer to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by the NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.
16. If the practitioner or the Trust does not agree to the case being referred to the NCAS, a panel hearing will normally be necessary.
17. The following procedure should be followed before the hearing:

Procedure to be followed prior to capability hearings

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

The hearing framework

18. The capability hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of 3 people, normally 2 members of the Trust, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust.

As far as is reasonably possible or practical, no member of the panel or advisers to the panel should have been previously involved in the investigation although it is permitted for its Medical Director to sit on the panel, provided he or she was not the case manager. In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

19. Arrangements must be made for the panel to be advised by:

- A senior member of staff from Human Resources, and
- A senior clinician from the same or similar clinical specialty as the practitioner concerned, but from another NHS employer (unless such an individual is already appointed as a panel member).
- A representative of a university if provided for in any protocol as mentioned in paragraph 18.

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

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

Representation at capability hearings

21. The hearing is not a court of law. Whilst the practitioner should be given every reasonable opportunity to present his or her case, the hearing should not be conducted in a legalistic or excessively formal manner.

The Trust are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg the medical staff committee or local negotiating committee.

22. The practitioner may be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organisation. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

Conduct of the capability hearing

23. The hearing should be conducted as follows:

- The panel and its advisers (see paragraph 19), the practitioner, his or her representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire.
- The Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing.
- The procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:
 - The witness to confirm any written statement and give any supplementary evidence.
 - The side calling the witness can question the witness.
 - The other side can then question the witness.
 - The panel may question the witness.
 - The side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

The order of presentation shall be:

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

- The Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation.
- The panel shall then retire to consider its decision.

Decisions

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

Possible decisions made by the capability panel

- No action required.
- Oral agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved (stays on employee's record for 6 months)
- Written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved (stays on employee's record for 1 year)
- Final written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved (stays on employee's record for 2 years)
- Termination of contract.

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

25. A record of oral agreements and written warnings should be kept on the practitioner's personnel file but should be removed following the specified period.
26. The decision of the panel should be communicated to the parties as soon as possible and normally within 5 working days of the hearing. Because of the complexities of the issues under deliberation and the need for detailed consideration, the parties should not necessarily expect a decision on the day of the hearing.
27. The decision must be confirmed in writing to the practitioner. This notification must include reasons for the decision, clarification of the practitioner's right of appeal and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

Where formal action is taken and a warning issued, the employee's next salary increment will be deferred by the equivalent duration of the warning (6, 12 or 24 months). This must be communicated to the employee in writing when their warning is confirmed.

APPEALS PROCEDURES IN CAPABILITY CASES

Introduction

28. Given the significance of the decision of a capability panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place.. There is no requirement for the Trust to set up a procedure for appeal against exclusion or investigation as these are adjuncts to the stages of the decision making process on what future action to take. The procedure for handling issues about the classification of a case as misconduct is dealt with previously in this framework.
29. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel in arriving at their decision acted fairly and reasonably based on:
 - A fair and thorough investigation of the issue;
 - Sufficient evidence arising from the investigation or assessment on which to base the decision;
 - Whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not rehear the entire case (see paragraph 31 below).

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

The appeal process

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

re-heard, the Chairman of the panel shall have the power to instruct a new capability hearing.

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

The appeal panel

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

Membership of the appeal panel

- An independent member (trained in legal aspects of appeals) from an approved pool. This person is designated Chairman.
 - The Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal.
 - A medically qualified member (or dentally qualified if appropriate) who is not employed by the Trust who must also have the appropriate training for hearing an appeal.
 - In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.
34. The panel should call on others to provide specialist advice. This should normally include:
- A Consultant from the same specialty or subspecialty as the appellant, but from another NHS employer.
 - A Senior Human Resources specialist.

Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

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

35. The Trust should arrange the panel and notify the appellant as soon as possible. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant's objections should be noted carefully. Trusts are reminded of the need to act reasonably at all stages of the process.
36. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability hearing. The following timetable should apply in all cases:
 - Appeal by written statement to be submitted to the Director of Human Resources) within 25 working days of the date of the written confirmation of the original decision.
 - Hearing to take place within 25 working days of date of lodging appeal.
 - Decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.
37. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement. The case manager should be informed and is responsible for ensuring that extensions are absolutely necessary and kept to a minimum.

Powers of the appeal panel

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

Conduct of appeal hearing

41. All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence.
42. The practitioner may be represented in the process by a friend, partner or spouse, colleague or a representative who may be from or retained by a trade union or defence organisation. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.
43. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.
44. The panel, after receiving the views of both parties, shall consider and make its decision in private.

Decision

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

Action following hearing

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

TERMINATION OF EMPLOYMENT WITH PERFORMANCE ISSUE UNRESOLVED

47. Where the employee leaves employment before disciplinary procedures have been completed, the investigation must be taken to a final conclusion in all cases and capability proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.
48. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the Trust

should invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The Trust must make a judgement, based on the evidence available, as to whether the allegations about the practitioner's capability are upheld. If the allegations are upheld, the Trust must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children Act List (held by the Department for Education and Skills).

49. If an excluded employee or an employee facing capability proceedings becomes ill, they should be subject to the Trust's usual sickness absence procedures. The sickness absence procedures take precedence over the capability procedures and the Trust should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the Occupational Health Service. The Occupational Health Service will advise the employer on the expected duration of the illness and any consequences it may have for the capability process and will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the Trust form a judgement as to whether the allegations are upheld.
50. If, in exceptional circumstances, a hearing proceeds in the absence of the practitioner, for reasons of ill-health, the practitioner should have the opportunity to submit written submissions and/or have a representative attend in his absence.
51. Where a case involves allegations of abuse against a child, the guidance issued to the NHS in September 2000, called "The Protection of Children Act 1999 – A Practical Guide to the Act for all Organisations Working with Children" gives more detailed information. A copy can be found on the Department of Health website¹¹.

Maintaining High Professional Standards in the Modern NHS

V. Handling concerns about a practitioner's health

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Maintaining High Professional Standards in the Modern NHS

VI. HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH

Introduction

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

Retaining the services of individuals with health problems

3. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk.

Examples of action to take

- sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- remove the practitioner from certain duties;
- reassign them to a different area of work;
- arrange re-training or adjustments to their working environment, with appropriate advice from the NCAS and/or deanery, under reasonable adjustment provision in the Disability Discrimination Act 1995.

Reasonable adjustment

3. At all times the practitioner should be supported by the Trust and the Occupational Health Service who should ensure that the practitioner is offered every available resource to get back to practise where appropriate. Employers should consider what reasonable adjustments could be made to their workplace conditions or other arrangements.

Examples of reasonable adjustment

- Make adjustments to the premises
- Re-allocate some of the disabled person's duties to another
- Transfer employee to an existing vacancy
- Alter employee's working hours or pattern of work
- Assign employee to a different workplace
- Allow absence for rehabilitation, assessment or treatment

- Provide additional training or retraining
 - Acquire/modify equipment
 - Modifying procedures for testing or assessment
 - Provide a reader or interpreter
 - Establish mentoring arrangements
5. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency Advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures where appropriate.

HANDLING HEALTH ISSUES

6. Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine a health problem. If the report recommends OHU involvement, the nominated manager must immediately refer the practitioner to a qualified, usually a consultant, occupational physician with the Occupational Health Service.
7. The NCAS should be approached to offer advice on any situation and at any point where the employer is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.
8. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with HR, the Medical Director or case manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate)

The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative.

Confidentiality must be maintained by all parties at all times.

9. If a doctor or dentist's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and the professional regulatory body must be informed, irrespective of whether or not they have retired on the grounds of ill health.
10. In those cases where there is impairment of performance solely due to ill health, disciplinary procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the Trust to resolve the underlying situation e.g. by repeatedly refusing a referral to the Occupational Health Service (OHS) or the NCAS. In these circumstances the procedures in part IV should be followed.

11. There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the trust is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHU under these circumstances, may give separate grounds for pursuing disciplinary action.

12. Special Professional Panels (generally referred to as the “three wise men”) were set up by District Health Authorities under circular HC(82)13. This responsibility was not transferred to Trusts and the process has fallen into disuse in most parts of the country. This part of the framework replaces HC(82)13 which is cancelled and any existing panels should be disbanded.

Maintaining High Professional Standards in the Modern NHS

Guidance on clinical academics

(including an Outline Protocol between University and Trust)

CLINICAL ACADEMICS

Background

The "Restriction of Practice and Exclusion from Work Directions 2003" direct NHS bodies to comply with the framework contained within the document "Maintaining High Professional Standards in the Modern NHS". This introduced a new framework for the initial handling and investigation of concerns about the conduct and performance of medical and dental employees. It also introduced a framework for restriction of practice and exclusion from work; it replaces existing guidance on the suspension of doctors and dentists. In the framework the Department said that NHS bodies must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with honorary contracts. This should be achieved by agreeing a protocol. The draft model protocol mentioned in the framework is attached to this guidance note.

GUIDANCE

1. The Follett report made a number of recommendations about disciplinary procedures. In particular it said:

“..we are quite clear that here too robust joint working must be the norm. However, we believe that joint working must extend to the prior phase of managing and helping poor performance and seeking remedial measures. It is only when these have run their course without success that formal disciplinary procedures come into play.”

2. In discussions with the Universities and Colleges Employers Association (UCEA), Universities UK (UUK), and the Council of Heads of Medical Schools (CHMS), the Department of Health has agreed that the following four key elements are necessary for the successful handling of concerns about a doctor with both an honorary and substantive contract:

- Appraisals are jointly undertaken by the University and the Trust.
- The express permission of the doctor involved is obtained for the exchange of both personal data (for example name, address, registration number, qualifications) and sensitive personal data (for example medical records) between University and Trust.
- Honorary NHS contracts for clinical academic staff contain a clause that states that the employee must have a substantive contract with the University to hold the honorary NHS post, and that, if the University post is terminated, for

whatever reason, the Trust reserves the right to review the continuation of the honorary contract (the “inter-dependency clause”).

- The Trust and University develop strong, co-partnership relations with each other and ensure jointly agreed procedures are in place for dealing with any concerns about doctors with honorary NHS contracts.
3. Similar arrangements should apply to doctors holding honorary academic contracts with a university.
 4. A Revised Model Statute for universities on dismissal, discipline and grievance procedures for academic staff has been approved by the Privy Council, and recommended to universities. It will be for them to decide on implementation. The UCEA has urged them to implement the provisions within the Revised Model Statute relating to clinical academic staff as soon as possible.
 5. The success of the contracts rests with the joint working of the university and the Trust. Although each employer (university or NHS Trust) can only make a decision to discipline or dismiss a member of staff under its own procedures. It is therefore recommended that a protocol should be agreed to permit the joint working necessary to ensure contractual inter-dependence, if both employers choose that route. Implementation of the Revised Model Statute will enable universities to adopt the new procedures.
 6. A draft protocol - “Outline Protocol between University and Trust”- is attached as an appendix. This provides for a good practice way of working, with reference to disciplinary matters and dismissal.

APPENDIX

OUTLINE PROTOCOL BETWEEN UNIVERSITY AND TRUST

1. The following general principles and procedure are the result of agreement between the Newcastle upon Tyne University and the Newcastle upon Tyne Hospitals NHS Foundation Trust (hereafter called "the Trust") in which University clinical academic staff may hold honorary NHS contracts and is intended to provide a framework for co-operation between the University and the Trust as employers of the clinical academic staff.

General Principles

2. The substantive academic contract and the NHS honorary contract are both contracts of employment. The clinical academic will therefore have two employers, each of whom will have obligations to the employee under its respective contract of employment and arising (for example under statute) from the employment relationship generally.
3. However, the University and the Trust recognise that as far as possible those separate employment relationships should be regarded as a whole, reflecting the fact that the performance of the clinical duties under the honorary NHS contract is essential for the full and proper performance of the duties under the substantive academic contract.
4. The University and the Trust should therefore seek to ensure joint co-operation in their dealings with the member of clinical academic staff, in particular with regard to issues of appraisal, review, dismissal and discipline.

Contracts of Employment

5. The University and the Trust will seek to ensure that their contracts (honorary or substantive) contain provisions which facilitate such joint co-operation and shall discuss on a regular basis the contents of the contracts which each will issue to clinical academics.

Disciplinary and other Procedures

6. The University and the Trust acknowledge that as employers of the clinical academic member of staff, each may wish, during the employment of the clinical academic concerned, to take action (whether in terms of dismissal or action falling short of dismissal) in respect of matters such as:
 - a) misconduct or alleged misconduct
 - b) performance of the duties of employment to a satisfactory standard
 - c) assessing medical fitness to undertake all or part of the duties of employment

(including consideration of the making of reasonable adjustments under the Disability Discrimination Act 1995 where the obligation to make such adjustments applies)

- d) attendance
 - e) redundancy or other re-organisation
7. The University and the Trust acknowledge that each has procedures for determining such issues in respect of its relationship with the member of clinical academic staff.
8. The University and the Trust acknowledge that:
- a) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s), and the Trust does not (and vice versa);
 - b) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s) and the Trust also has grounds for considering action against the same employee under its own appropriate procedure(s); and
 - c) that if the University or the Trust terminates the substantive or honorary contract (as the case may be), the other will need to consider whether, in the light of that termination, the remaining contract can be continued or ought to be terminated and that, while each case will need to be considered on its own facts, it is appropriate for the University and the Trust to agree in general terms a framework for the handling of such matters.
9. The University and the Trust therefore agree that:
- a) issues of conduct are matters which would ordinarily fall to be dealt with under the University's disciplinary procedure
 - b) issues of conduct are matters which would ordinarily fall to be dealt with under the Trust's disciplinary procedure and
 - c) in cases where an issue of misconduct arises under both (a) and (b) above, the University and the Trust will need to determine on the facts of each case which procedure will take priority.

Potential Dismissal on the Grounds of Misconduct

10. Where either the University or the Trust has grounds for considering the dismissal of a member of clinical academic staff on the grounds of misconduct:
- a) the party considering the instigation of disciplinary procedures which may result in dismissal shall notify the other of that fact and shall discuss with the

other the circumstances which have led it to contemplate initiating proceedings.

- b) the University and the Trust will co-operate with each other to facilitate any investigation into the alleged misconduct.
 - c) the University and the Trust shall consider whether the case is such that both parties would have grounds for instituting disciplinary proceedings and, if that is the case, agree whether action is to be taken under each of their appropriate disciplinary procedures and the sequence in which those procedures shall be operated.
 - d) any party considering restriction of practice or exclusion from work of the clinical academic shall advise the other of its proposal to restrict or suspend and discuss this prior to the clinical academic being so restricted or suspended, where it is practical to do so.
 - e) the University and the Trust shall liaise with each other on the steps to be taken under the applicable disciplinary procedure or procedures, in particular as regards representation by both employers on any disciplinary panel established under any of their applicable procedures and the facilitation of the calling of witnesses and/or the production of documentary evidence necessary for the purpose of determining whether misconduct has occurred.
 - f) the University and the Trust (as the case may be) shall keep the other informed of the progress and outcome of their respective procedures, including of any appeal.
11. While the University and the Trust shall co-operate with each other as described above, each acknowledges that the other has the ultimate right to determine whether or not disciplinary proceedings should be instigated, to determine whether misconduct has occurred and, if so, whether dismissal is the appropriate sanction to be applied on the facts of that case. Representation of the Trust on the University's disciplinary panels (and vice versa) does not mean that that the Trust's representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and vice versa).

Joint Appraisal

12. The University and the Trust shall agree procedures for the joint appraisal of members of clinical academic staff and ensure that such arrangements are referred to in the terms of the substantive and honorary contracts issued to the member of staff.

Dismissal on Performance, Absence or Ill-Health Grounds

13. In the event that either the Trust or the University considers that there are grounds for considering the dismissal of a member of clinical academic staff on the grounds of performance, absence or health grounds, each will advise the other of that fact and shall discuss:
 - a) whether action is to be taken under the procedures of the University or the Trust or both (and if both, which procedure shall take priority);
 - b) whether it is appropriate to consider the restriction of practice or exclusion from work of the member of staff concerned in relation to either the academic or clinical duties or both. Any party considering restriction of practice or exclusion from work of the clinical academic member of staff shall advise the other if its proposal to restrict or exclude and discuss this prior to the clinical academic member of staff being restricted or excluded where it is practical to do so; and
 - c) (in cases of sickness absence, or medical incapacity) whether it is necessary to obtain a medical report from an Occupational Health adviser or from an independent medical expert on the ability of the employee to perform the duties of his/her employment. The University and the Trust shall discuss the questions/issues to be raised with such medical adviser, in particular any issues arising under the Disability Discrimination Act 1995, including any duty to make reasonable adjustments.
14. The University and the Trust shall keep each other advised of the actions taken under their applicable procedures, including the outcome of any appeal.
15. While the University and the Trust shall co-operate with each other as described above, each acknowledges that the other has the ultimate right, in relation to any matter being dealt with under its procedures, to determine whether or not to dismiss the member of staff concerned. Representation of the Trust on the University panel (and vice versa) does not mean that that representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and vice versa).

Dismissal on the grounds of redundancy or re-organisation

16. In the event that either the Trust or the University is contemplating the dismissal for redundancy or other re-organisational reasons of any member of clinical academic staff it shall advise the other of this fact and shall keep the other regularly informed of the action being taken in this respect.

Other general provisions regarding co-operation

17. The University and Trust shall ensure that:
 - a) their respective procedures provide that, while either the University's or the Trust's disciplinary procedure is being applied to a member of clinical

academic staff, that individual may not bring any complaint relating to those proceedings under the grievance procedure of the other employer (ie of the Trust or the University, as the case may be).

- b) rights of appeal will be confined solely to the procedure which is being implemented and individual employees may not appeal across procedures to the other party (i.e. the University or the Trust as the case may be).
- c) their contracts of employment and procedures are as far as possible sufficient to allow the disclosure of information from one to the other (in particular of personal data or sensitive personal data) under the Data Protection Act 1998, whether with or without the consent of the member of staff concerned. The Trust and the University will also discuss and agree guidelines for the disclosure of data regarding third parties, in particular data relating to patients.

18. The University and the Trust shall meet on a regular basis to review this Agreement and its operation.

Audit & Monitoring

Operation of this policy will be monitored by the Director of Human Resources. The organisations' figures will be presented to the Heads of Human Resources Meeting on an annual basis, who will identify appropriate action plans to address any areas of concern and will continue to monitor the plan until its completion.

Monitoring will include reporting of information on the Electronic Staff Record and file audits for the purposes of:

- a) Identifying the number of employees subject to formal action
- b) Monitoring the timeliness of process start and end dates

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Capability Procedure to Address Concerns regarding competence of medical and dental staff	Policy Author:	I Palfreeman
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	No	
4(b).	If so can the impact be avoided?	-	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	-	
4(d)	Can we reduce the impact by taking different action?	-	

Comments:	Action Plan due (or Not Applicable):

Name and Designation of Person responsible for completion of this form: I Palfreeman, Head of Medical & Dental, Planning & Reward..... Date: 15.7.2010.....

Names & Designations of those involved in the impact assessment screening process: ... CPG

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Helen Lamont, Director of Nursing, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.