South East Coast Ambulance Service NHS
NHS Foundation Trust

Managing Concerns about Medical Staff Policy and Procedure

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Contents

1 Purpose

1.1. The purpose of this policy is to outline the action to be taken when a concern about a doctor first arises; the procedure for considering whether there needs to be restrictions placed on a doctor's practice or whether exclusion is considered necessary.

1.2. The policy also sets out the Trust's procedure for handling conduct and disciplinary procedures, capability and concerns about a practitioner's health.

1.3. This policy and procedure is consistent with the *Maintaining High Professional Standards in the Modern NHS* framework and has been developed to ensure that disciplinary matters are managed in accordance with good practice guidance and the relevant employment and equalities legislation.

2 Scope

2.1. This policy covers all medical employees of South East Coast Ambulance Service NHS Foundation Trust.

2.2. This policy does not apply to bank or agency medical workers or medical workers engaged under a service level agreement, contract for service or honorary academic or clinical academic arrangement. Any concerns about the conduct and/or capability of workers in these categories should be referred to the HR team for further advice. If the Bank or Agency worker is a General Practitioner, notification to the NHS England Responsible Officer must be considered.

2.3. Professional healthcare staff are responsible for complying with the relevant standards set by their regulatory or professional bodies. A breach of such standards may lead to action by the Trust independent of any taken by the regulatory or professional body concerned.

2.4. For the sake of clarity, the term "practitioner" refers to doctors.

3 Definitions

Disciplinary Hearing	Meeting at which a decision is made as to whether a sanction should be applied
Disciplinary Investigation	A process of fact finding in relation to an allegation of misconduct
Investigating Officer	A person who carries out an investigation to establish the facts into an allegation of misconduct

Case Manager	The person who is responsible for commissioning a disciplinary investigation and taking a decision about whether or not formal disciplinary action is required
Exclusion	A neutral act, of up to but no more than four weeks at a time. Applies in cases where the practitioner's presence at work presents an unacceptable risk. The practitioner is not required to attend work and normally continues to be paid

4 Part I – Action When a Concern Arises

4.1 Introduction to Policy

4.1.1 The management of performance is a continuous process which is intended to identify problems.

4.1.1 Numerous ways exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to disciplinary procedures.

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

4.1.2.1 Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff;

4.1.2.2 Management supervision, review of performance against job plans, annual appraisal, revalidation;

4.1.2.3 Monitoring of data on performance and quality of care;

4.1.2.4 Clinical governance, clinical audit and other quality improvement activities;

4.1.2.5 Complaints about care by patients or relatives of patients;

4.1.2.6 Information from the regulatory bodies;

4.1.2.7 Litigation following allegations of negligence;

4.1.2.8 Information from the police or coroner;

4.1.2.9 Court judgements.

4.1.3 Unfounded and malicious allegations can cause lasting damage to a doctor's reputation and career prospects. Therefore, all allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to verify the facts so that the allegations can be shown to be true or false.

4.1.4 Root cause analysis of a problem may show the causes are more broadly based and can be attributed to systems and/or organisational failures rather than a doctor's performance and will require appropriate investigation and remedial actions.

4.2 Identifying Minor Conduct Issues

4.2.1 Feedback and discussion on conduct issues should form part of management supervision or '1 to 1' meetings. In most cases, matters of minor misconduct can be addressed and resolved quickly through informal discussion.

4.2.2 However, if the issues persist or are particularly serious, further management action should be taken in line with this policy without undue delay.

4.3 Exploratory Discussion and Informal Resolution

4.3.1 When a manager becomes concerned about the conduct of a practitioner, they should meet with them to outline their concerns and explain the improvements that need to be made; find out the practitioner's perspective and what reasonable support, guidance or adjustments will enable the practitioner to achieve the necessary improvements.

4.3.2 Resolution measures may include but are not limited to: agreement to a change of duties; undergo training or re-training; agreement to a behavioural contract; an increase to the practitioner's work experience in a particular area. If informal resolution is not agreed to, then formal action in line with this policy will begin.

4.3.3 If the cause of the problem is the practitioner's health, skills or ability, refer to the capability and health sections of this policy (Section 7 and 8).

4.3.4 If the practitioner is experiencing an underlying health problem, the manager should discuss referral to occupational health and get the practitioner's consent in line with the Trust's Managing Sickness Absence Policy.

4.3.5 If the practitioner is concerned about working arrangements or working relationships, the manager should look into these and feed back to the practitioner any steps that will be taken to resolve them.

4.3.6 When the necessary advice has been received and/or guidance e.g. through the National Clinical Assessment Service (NCAS), support and/or adjustments have been identified and arranged, the manager should consider whether they remain concerned about the practitioner's conduct. If so, they should take formal action in line with this policy.

4.4 Doctors in Training

4.4.1 Concerns about the capability or conduct of doctors in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.

4.5 Registering Serious Concerns

4.5.1 All serious concerns must be registered with the Chief Executive Officer and they must ensure that a case manager is appointed.

4.5.2 The Chair of the Board must designate a non-executive member, "the designated member", to oversee the case and ensure that momentum is maintained.

4.5.3 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 Executive Medical Director will need to work with the Director responsible for Human Resources to decide the appropriate course of action in each case.

4.5.4 The Executive Medical Director will usually act as the case manager in cases involving the Deputy Medical Director. The Deputy Medical Director will usually act as the case manager in cases involving Assistant Medical Directors. Assistant Medical Directors will usually act as case manager for consultants and other practitioners. If concerns are raised about the Executive Medical Director, the Chief Executive will act as the case manager and should seek the professional advice of the Regional Medical Director, NHS England and Improvement.

4.5.5 If concerns about the doctor include safeguarding of adults or children, advice should be sought from the Trust's safeguarding team as to how these concerns are managed in parallel to the use of this policy.

4.5.6 The Executive Medical Director or their deputy is responsible for appointing a case investigator.

4.6 Referral to the Regulatory Body

4.6.1 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 General Medical Council (GMC), whether or not the case has been referred to NCAS.

4.7 Issue of Alert Letters and Sharing of Information

4.7.1 Consideration will be given as to whether the issue of an 'alert letter' should be requested from NCAS when there is a pressing need to inform

potential employers of unresolved concerns which could result in significant risk to patients and/or public safety.

4.7.2 When exclusions from work take place, the case manager is responsible for ensuring a copy of the monthly Board exclusion return is sent to NCAS at MHPS@ncas.nhs.uk. (Section 5).

4.7.3 SECAmb currently does not have a Responsible Officer as all the doctors employed in the organisation are under the Responsible Officer (RO) regulations of their host organisations. The Executive Medical Director is responsible for informing the Doctor's RO of any concerns managed under this policy. Under the Medical Profession (Responsible Officers) Regulations 2011 and Amendments, the Responsible Officer for the doctor will consider whether there is a need to share information with other organisations where the doctor practices via the national Medical Practice Information Transfer Form.

4.7.4 Failure of a doctor to provide details of other places of work (NHS and non-NHS) may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients.

4.8 Exclusion

4.8.1 When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Section 5 of this document sets out the procedures for this action.

4.9 Appointment of a Case investigator

4.9.1 The Case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings.

4.9.2 When a Case investigator is appointed, the terms of reference for the investigation should be determined by the Case Manager, usually in consultation with an HR Business Partner or Head of HR. The terms of reference should be agreed with the practitioner.

4.9.3 If the Case investigator is not a clinician, they should involve a senior member of the medical staff where a question of clinical judgement is raised during the investigation process. (Where no other suitable senior doctor is employed by the Trust a senior doctor from another NHS body should be approached).

4.9.4 The Case investigator ensures that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as

possible. Patient confidentiality needs to be maintained but any disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how – within the boundaries of the law – that information should be gathered. The investigator will approach the practitioner concerned to seek views on information that should be collected.

4.9.5 The Case investigator ensures that there are sufficient written statements collected to establish a case prior to a decision to convene any disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report.

4.9.6 The Case investigator ensures that a written record is kept of the investigation, the conclusions reached, and the course of action agreed and assists the delegated board member in reviewing the progress of the case.

4.10 **The Investigation**

4.10.1 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.

4.10.2 The practitioner concerned must be informed in writing by the case manager as soon as it has been decided that an investigation is to be undertaken, they must be told the name of the case investigator and made aware of the specific allegations or concerns that have been raised.

4.10.3 The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the case investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied.

4.10.4 At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing by a representative. In addition to statutory rights under the Employment Act 2008, the representative may be another employee of the NHS Trust; an official or representative of the British Medical Association or any other recognised trade union, or a defence organisation; or a friend, partner or spouse. The representative may be legally qualified but he or she will not be acting in a legal capacity.

4.10.5 The Case investigator has discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended simply to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter.

4.10.6 If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager must arrange for a practitioner in the same specialty and same grade from another NHS body to assist.

4.10.7 The case investigator should complete the investigation within 4 weeks of appointment and submit their report to the case manager within a further 5 days. The report of the investigation should give the case manager sufficient information to enable them to make a decision whether:

4.10.7.1 There is a case of misconduct that should be put to a conduct panel;
4.10.7.2 There are concerns about the practitioner's health that should be considered by the SECAmb occupational health service;
4.10.7.3 There are concerns about the practitioner's performance that should be further explored by the NCAS;
4.10.7.4 Restrictions on practice or exclusion from work should be considered;
4.10.7.5 There are serious concerns that should be referred to the GMC;
4.10.7.6 There are intractable problems and the matter should be put before a capability panel;
4.10.7.7 No further action is needed.

4.11 Involvement of NCAS

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

4.11.2 The focus of NCAS’s work is therefore likely to involve performance difficulties which are serious and/or repetitive. That means:

4.11.2.1 Performance falling well short of what doctors could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk;
4.11.2.2 Alternatively or additionally, problems that are on-going or (depending on severity) have been encountered on at least two occasions.
4.11.2.3 In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process. The NCAS may advise on this.
4.11.2.4 Where the Trust is considering excluding a doctor (whether or not his or her performance is under discussion with the NCAS), the Trust will inform the NCAS of this at an early stage, so that alternatives to exclusion are considered.
4.11.2.5 Procedures for exclusion are covered in section 5 of the procedure. It is particularly desirable to find an alternative when 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.

4.11.2.6 A practitioner undergoing assessment by 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. (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").

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

4.12 Confidentiality

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

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

5 PART II – Restriction of Practice and Exclusion

5.1 The Trust will ensure that:

5.1.1 Exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;

5.1.2 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;

5.1.3 All extensions of exclusion are reviewed and a brief report provided to the Chief Executive Officer and the Board;

5.1.4 A detailed report is provided when requested to a single non-executive member of the Board (the "Designated Board Member") who will be responsible for monitoring the situation until the exclusion has been lifted.

5.2 Managing the Risk to Patients

5.2.1 When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Exclusion will be considered as a last resort if alternative courses of action are not feasible.

5.2.2 Exclusion of clinical staff from the workplace is a temporary expedient. Exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work will be reserved for only the most exceptional circumstances.

5.2.3 Exclusion will only be used:

5.2.3.1 To protect the interests of patients or other staff; and/or

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

5.2.4 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 of the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

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

5.2.5.1 Supervision of normal contractual clinical duties;

5.2.5.2 Restricting the practitioner to certain forms of clinical duties;

5.2.5.3 Restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling;

5.2.5.4 Sick leave for the investigation of specific health problems.

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

5.3 The Exclusion Process

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

5.4 Roles within the Exclusion Process

5.4.1 The Trust Chief Executive Officer has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by persons with the authority to exclude.

5.4.2 The case will be discussed fully with the Chief Executive Officer, the Executive Medical Director, the HR Director, NCAS and other interested parties (such as the police where there are serious criminal allegations or the Counter Fraud & Security Management Service) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

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

5.4.3.1 Chief Executive Officer
5.4.3.1 Executive Medical Director
5.4.3.2 Deputy Medical Director
5.4.3.3 Assistant Medical Director/s
5.4.3.4 HR Director
5.4.3.5 Executive Director on-call

5.4.4 The Case Manager will appoint a Case investigator to explore and report on the circumstances that have led to the need to exclude the staff member. The investigating officer will provide factual information to assist the case manager in reviewing the need for exclusion and making progress reports to the Chief Executive Officer and designated Board member.

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

5.4.6 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.

5.5 Immediate Exclusion

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

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

5.5.2 Such an exclusion will allow a more measured consideration to be undertaken and the NCAS should be contacted before the immediate exclusion takes place. This period should be used to carry out a preliminary situation analysis, to seek further advice from the NCAS and to convene a case conference.

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

5.6 Formal Exclusion

5.6.1 A formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude.

5.6.2 NCAS must be consulted where formal exclusion is being considered. If a case investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for the case conference. This preliminary report is advisory to enable the case manager to decide on the next steps as appropriate.

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

5.6.3.1 The allegation appears unfounded; or
5.6.3.2 There is a potential misconduct issue; or
5.6.3.3 There is a concern about the practitioner's capability; or
5.6.3.4 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.

5.6.4 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.

5.6.5 When the practitioner is informed of the exclusion, there should be a witness present and the nature of the allegations or areas of concern should

be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction).

5.6.6 The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises and the need to remain available for work) and that a full investigation or what other action will follow. The practitioner and their representative not acting in a legal capacity 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.

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

5.6.8 If the case manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred to the NCAS 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.

5.6.9 If at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the case manager must lift the exclusion, inform NCAS and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

5.7 Exclusion from Premises

5.7.1 Practitioners will not be automatically barred from the premises upon exclusion from work. The case manager must always consider whether a bar from the premises is absolutely necessary.

5.7.2 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.

5.8 Keeping in contact and availability for work

5.8.1 The practitioner should be allowed to retain contact with colleagues for matters unconnected with the investigation, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

5.8.2 Exclusion under this procedure will be on full pay, therefore the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continuing to undertake such work or to take annual leave or study leave. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the case manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

5.8.3 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 in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

5.9 Informal Exclusion

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

5.10 Keeping exclusions under review: Informing the Board

5.10.1 The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. Therefore:

5.10.2 A summary of the progress of each case at the end of each period of exclusion will be provided to the Board, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible;

5.10.2.1 A monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended will be provided with a copy sent to NCAS.

5.11 Regular Review

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

5.11.2 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.

5.11.3 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.

5.11.4 It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review.

5.11.5 Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

5.11.6 The Trust must take review action before the end of each 4-week period. After three exclusions, advice from NCAS should be sought. The information below outlines the activities that must be undertaken at different stages of exclusion.

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

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

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

5.12.1.1 The case manager decides on next steps as appropriate, taking into account the views of the practitioner. Further renewal may be for up to 4 weeks;

5.12.1.2 The case manager submits an advisory report of outcome to Chief Executive and the Trust Board;

5.12.1.3 Each renewal is a formal matter and must be documented as such;

5.12.1.4 The practitioner must be sent written notification on each occasion.

5.13 Third Review

5.13.1 If the practitioner has been excluded for three periods:

5.13.1.1 A report must be made to the Chief Executive outlining the reasons for the continued exclusion, why restrictions on practice would not be an appropriate alternative, and if the investigation has not been completed, a timetable for completion of the investigation;

5.13.1.2 The Chief Executive must report to NCAS and the designated Board member

5.13.1.3 The case must formally be referred to NCAS explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion, at the earliest opportunity;

5.13.1.4 The NCAS will review the case and advise the Trust on the handling of the case until it is concluded.

5.14 Six Months Review

5.14.1 If the exclusion has been extended over six months:

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

5.14.1.2 NCAS 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.

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

5.15 Appeal

5.15.1 At any stage when a practitioner is excluded or has restrictions placed on their practice, they may appeal to the Chief Executive or designated Board member who will ensure an appropriately constituted panel is set up. Once an appeal has been considered the practitioner will not be allowed to appeal again for a period of 3 months.

5.16 The role of NCAS in monitoring Exclusions

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

5.17 The role of the Board and Designated Member

5.17.1 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.

5.17.2 The Chair is responsible for designating a non-executive member 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.

5.17.3 This member's responsibilities include:

5.17.3.1 Receiving reports and reviewing the continued exclusion from work;
5.17.3.2 Considering representations from the practitioner about his or her exclusion;
5.17.3.3 Considering any representations about the investigation.

5.18 Return to work

5.18.1 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.

6 PART III – Conduct Hearings and Disciplinary Matters

6.1 Introduction

6.1.1 Misconduct matters for doctors, as for all other staff groups, are dealt with under the Trust’s Disciplinary Procedures. However, where any concerns about the performance or conduct of a practitioner are raised, the Trust will contact NCAS for advice before proceeding.

6.1.2 Where the alleged misconduct being investigated under the above policy relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice.

6.1.3 Similarly where a case involving issues of professional conduct proceeds to a hearing under the Trust’s conduct procedures the panel must include a member who is medically qualified (in the case of doctors) and who is not currently employed by the organisation. The Trust will discuss the selection of the medical panel member with the Local Negotiating Committee chair.

6.1.4 The Trust’s Disciplinary Procedure sets out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be “misconduct” and examples are set out in the

procedure. Examples of issues that should be investigated as capability under that Procedure are set below.

6.1.5 Any allegation of misconduct against a doctor 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.

6.1.6 Although it is for the Trust to decide upon the most appropriate way forward having consulted NCAS and their own employment law specialist, the Trust will also consult with a representative of the Local Negotiating Committee to determine which procedure, if any, should be followed, in the event of a dispute.

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

6.2 Action when Investigations Identify Possible Criminal Acts

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

6.3 Cases where Criminal Charges are brought not connected with an Investigation by the Trust

6.3.1 There are some criminal offences that, if proven, could render a doctor or unsuitable for employment. In all cases, the Trust, having considered the facts, will need to consider whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner.

6.3.2 The Trust will give serious consideration to whether the employee can continue in their job once criminal charges have been made. Bearing in mind the presumption of innocence, the Trust must consider whether the offence, if proven, is one that makes the doctor unsuitable for their type of work and whether, pending the trial, the employee can continue in their present job, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice will be sought from the Trust's HR or legal adviser. The Trust will explain the reasons for taking any such action to the practitioner concerned.

6.4 Dropping of charges or no court conviction

6.4.1 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.

6.4.1 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.

6.4.2 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 concerned. Where charges are dropped, the presumption is that the employee will be reinstated.

6.5 Terms of settlement on termination of employment

6.5.1 In some circumstances, terms of settlement may be agreed with a doctor if their employment is to be terminated. The Trust will follow the principles set out in the NHS Employers (2013) document: Use of Settlement Agreements and Confidentiality Clauses.

7 PART IV – Procedures for Dealing with Issues of Capability

7.1 Introduction and General Principles

7.1.1 There will be occasions where the Trust considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues.

7.1.2 Matters that should be described and dealt with as misconduct issues are covered in section 6 of this procedure.

7.1.3 Concerns about the capability of a doctor may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from NCAS will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, the matter must be referred to the NCAS before the matter can be considered by a capability panel (unless the practitioner refuses to have his or her case referred).

7.1.4 Matters which fall under the Trust's capability procedures include:

7.1.4.1 Out of date clinical practice;

7.1.4.2 Inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
7.1.4.3 Incompetent clinical practice;
7.1.4.4 Inability to communicate effectively with colleagues and/or patients;
7.1.4.5 Inappropriate delegation of clinical responsibility;
7.1.4.6 Inadequate supervision of delegated clinical tasks;
7.1.4.7 Ineffective clinical team working skills

This is not an exhaustive list.

7.1.5 Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through on-going assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. The NCAS will be consulted for advice to support the remediation of a doctor.

7.2 How to proceed where Conduct and Capability Issues involved

7.2.1 It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately.

7.2.2 Although it is for the Trust to decide upon the most appropriate way forward having consulted NCAS and their own employment law specialist, the Trust will also consult with a representative of the Medical Staff Committee/Local Negotiating Committee to determine which procedure, if any, should be followed, in the event of a dispute.

7.2.3 The practitioner is also entitled to use the Trust's grievance procedure if they consider that the case has been incorrectly classified. If this happens, the Trust will consider suspending the disciplinary procedure for a short period while the grievance is dealt with. The grievance should be in writing and should be heard under the Trust's procedure on a fast-track basis to avoid any excessive hold-ups in the process. Alternatively or in addition, they may make representations to the designated board member.

7.3 Duties of Employers

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

7.3.2 Capability may be affected by ill health and this will be considered in any investigation. Arrangements for handling concerns about a practitioner's health are described in Part 5 of this procedure.

7.3.3 The Trust will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds.

7.3.4 The Trust will ensure that managers and case investigators receive appropriate and effective training in the operation of this procedure. Those undertaking investigations or sitting on capability or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board will agree what training staff and Board members must have completed before they can take part in these proceedings.

7.4 The pre-hearing process

7.4.1 When a report of the Trust investigation under Part 1 of the procedure 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.

7.4.2 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.

7.4.3 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 NCAS. The case manager will need to consider urgently:

7.4.3.1 Whether action under Part 2 of the procedure is necessary to exclude the practitioner; or

7.4.3.2 To place temporary restrictions on their clinical duties.

7.4.4 The case manager will also need to consider with the Executive Medical Director and Human Resources Director whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to 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.

7.4.5 NCAS will assist the Trust in drawing up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned).

7.4.6 There may be occasions when a case has been considered by 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.

7.4.7 In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by NCAS advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

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

7.4.9 If a capability hearing is to be held, the following procedure will be followed beforehand:

7.4.9.1 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 representative not acting in a legal capacity to accompany them to the hearing if they so choose;

7.4.9.2 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;

7.4.9.3 Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not less than 30 working days), to proceed with the hearing in the practitioner's absence, although the Trust will act reasonably in deciding to do so, taking into account any comments made by the practitioner;

7.4.9.4 Should the practitioner's ill health prevent the hearing taking place the Trust will implement its usual absence procedures and involve the Occupational Health Department as necessary;

7.4.9.5 Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing.

7.4.9.6 Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chair will invite the witness to attend.

7.4.9.7 The Chair cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel will reduce the weight given to the evidence as there will not be the opportunity to challenge it properly.

7.4.9.8 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;

7.4.9.9 If witnesses who are required to attend the hearing choose to be accompanied, the accompanying person cannot participate in the hearing.

7.5 The Hearing Framework

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

7.5.2 As far as reasonably possible or practicable no member of the panel or advisers to the panel should have been previously involved in carrying out the investigation. In the case of clinical academics, a further panel member may be appointed in accordance with the Outline Protocol agreed between the Trust and the University of Sussex.

7.5.3 Arrangements must be made for the panel to be advised by a senior member of the HR Team; a senior clinician from the same or similar clinical speciality as the practitioner concerned, but from another NHS employer; a representative of a University if provided for in any protocol.

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

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

7.6 Representation at capability hearings

7.6.1 The practitioner will be given every reasonable opportunity to present his or her case, although the hearing should not be conducted in a legalistic or excessively formal manner.

7.6.2 The practitioner may be accompanied by a representative in the process. The representative may be a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

7.7 Conduct of capability hearing

7.7.1 The hearing should be conducted as follows:

7.7.1.1 The panel and its advisers, the practitioner, his or her representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;

7.7.1.2 The Chair of the panel will be responsible for the proper conduct of the proceedings. The Chair should introduce all persons present and announce which witnesses are available to attend the hearing;

7.7.1.3 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.

7.7.2 The order of presentation shall be:

7.7.2.1 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;

7.7.2.2 The Chair shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.

7.7.2.3 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;

7.7.2.4 The Chair shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification;

7.7.2.5 The Chair shall invite the Case Manager to make a brief closing statement summarising the key points of the case;

7.7.2.6 The Chair 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;

7.7.2.7 The panel shall then retire to consider its decision.

7.8 Decisions

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

7.8.2 No action required;

7.8.2.1 Oral agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved [stays on the employee's record for 6 months];

7.8.2.2 Written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved [stays on the employees' record for 1 year];

7.8.2.3 Final written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved [stays on the employee's record for 1 year];

7.8.2.4 Termination of contract.

7.8.3 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.

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

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

7.8.6 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 or any other external/professional body.

7.9 Appeals in Capability cases

7.9.1 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:

7.9.1.1 A fair and thorough investigation of the issue;

7.9.1.2 Sufficient evidence arising from the investigation or assessment on which to base the decision;

7.9.1.3 Whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

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

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

7.10 The Appeal Process

7.10.1 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 Chair of the panel shall have the power to instruct a new capability hearing.

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

7.11 The Appeal Panel

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

7.11.2 These members will be:

7.11.2.1 An independent member (trained in legal aspects of appeals) from an approved pool. This person will be appointed from the national list held by NHS Employers for this purpose. This person is designated Chair;

7.11.2.2 The Chair (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;

7.11.2.3 A medically qualified member who is not employed by the Trust who must also have the appropriate training for hearing an appeal. The Trust will discuss the external medical member with the Chair Local Negotiating Committee.

7.11.2.4 In the case of clinical academics, a further panel member may be appointed in accordance with the Protocol agreed between the Trust and the University of Sussex.

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

7.11.3.1 A consultant from the same specialty or subspecialty as the appellant, but from another NHS employer.

7.11.3.2 A senior human resources specialist who may be from another NHS organisation.

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

7.11.3.4 The Trust should make the arrangements for the panel and notify the appellant as soon as possible and in any event within the recommended timetable.

7.11.4 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.

7.11.5 If the practitioner raises a reasonable objection within five working days of notification, the Trust will need to review the panel's constitution and satisfy itself a panel is constituted that will reach a fair and objective decision. The practitioner will be notified of the outcome of this review in writing within five working days of the practitioner's objection. This must occur before the hearing can take place.

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

7.11.6.1 Appeal by written statement to be submitted to the designated appeal point (normally the Director responsible for Human Resources) within 25 working days of the date of the written confirmation of the original decision;

7.11.6.2 Hearing to take place within 25 working days of date of lodging appeal;
7.11.6.3 Decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

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

7.12 Powers of the Appeal Panel

7.12.1 The appeal panel has the right to call witnesses of its own volition, but must notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.

7.12.2 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.

7.12.3 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.

7.13 Conduct of Appeal Hearing

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

7.13.2 The practitioner may be represented in the process by a friend, partner or spouse, colleague or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

7.13.3 Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or their representative not acting in a legal capacity) can at this stage make a statement in mitigation.

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

7.14 Decision

7.14.1 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 Chair of the appeal panel.

7.15 Action Following Hearing

7.15.1 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.

7.16 Termination of employment with Performance Issues Unresolved

7.16.1 Whatever the circumstances, where an employee leaves employment before disciplinary procedures have been completed, any outstanding disciplinary investigation will be concluded and capability proceedings will be completed where possible.

7.16.2 Where employment ends before investigation or proceedings have been concluded, every reasonable effort will be made to ensure the former employee remains involved in the process. If contact with the employee has been lost, the Trust will invite them to attend any hearing by writing to both their last known home address and their registered address (the two will often be the same). The Trust will make a judgement, based on the evidence available, as to whether the allegations about the practitioner's capability are upheld. If the allegations are upheld, the Trust will take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children Act List (held by the Department for Education and Skills), informing the Responsible Officer/s of other organisations the practitioner works for.

7.16.3 If an excluded employee or an employee facing capability proceedings becomes ill, they will be subject to the Trust's Sickness Absence Policy and Procedure. The sickness absence procedures take precedence over the capability procedures and the Trust will take reasonable steps to give the employee time to recover and attend any hearing.

7.16.4 Where the employee's illness exceeds 4 weeks, they will be referred to the Occupational Health Service. The Occupational Health Service will advise the Trust on the expected duration of the illness and any consequences it may have for the capability process and will also be able to advise on the employee's capacity for future work, as a result of which the Trust may wish to consider retirement on health grounds.

7.16.5 Should employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the Trust form a judgement as to whether the allegations are upheld.

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

8 PART V – Handling Concerns about a Practitioner's Health

8.1 Introduction

8.1.1 A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of workplace factors such as stress.

8.1.2 The Trust's key principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS.

8.2 Retaining the Services of Individuals with Health Problems

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

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

8.2.2 This is not an exhaustive list.

8.3 Reasonable adjustment

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

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

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

8.4 Handling Health Issues

8.4.1 Where there is an incident that points to a problem with the practitioner's health, the incident may need to be investigated to determine a health problem. If the report recommends Occupational Health Service involvement, the nominated manager must immediately refer the practitioner to a qualified occupational physician (usually a consultant) with the Occupational Health Service.

8.4.2 NCAS should be approached to offer advice on any situation and at any point where the employer is concerned about a doctor. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.

8.4.3 The occupational physician should agree a course of action with the practitioner and send their recommendations to the Executive Medical Director.

8.4.4 A meeting should be convened with the Director of HR, the Executive Medical Director/case manager, the practitioner and case worker from the Occupational Health Service to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a representative not acting in a legal capacity 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.

8.4.5 If a doctor'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 referral to the professional regulatory body must be considered in accordance with the regulatory bodies requirements for employers, irrespective of whether or not they have retired on the grounds of ill health.

8.4.6 In those cases where there is impairment of performance solely due to ill health, disciplinary procedures will be considered only in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by repeatedly refusing a referral to Occupational Health Services or NCAS. In these circumstances the procedures in part 2 should be followed.

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

9 Responsibilities

Chief Executive Officer	Has ultimate responsibility for the organisation and is supported by the Executive Directors.
Case Manager	Identifies nature of problem or concern. Assesses the seriousness of the issue/s on the information available. Involves NCAS in all cases and the postgraduate dean where concern involves a doctor in training. In consultation, decides whether an informal approach to address problems can be taken or whether a formal investigation will be needed. Appoints a Case investigator where a formal route is taken Sets up case conferences. Undertakes to keep the practitioner informed. Considers "Alert Letter" process. Reviews exclusions before its expiry and reports to Board and Chief Executive Officer. Ensures formal arrangements are in place for the return to work of the practitioner. Keeps details of cases in accordance with principles of Data Protection Act and ensures confidentiality of cases e.g. no press notices or release of names.
Case investigator	Responsible for leading the investigation, establishing the facts in an unbiased way and reporting the preliminary and subsequent findings in writing within agreed timescales.

	Assists the Case Manager in reviewing the need for exclusion, making reports to the Chief Executive or designated Board Member. Is not responsible for making the decision on what action needs to be taken, or whether the employee should be excluded from work and may not be a member of any disciplinary panel relating to the case.
Director Responsible for HR & OD	Works with the Case Manager in a consultative role Provides or ensures expert HR advice available at all stages.
Designated Board Member	Reviews the progress of the case. Maintains 'case momentum' including consistency of time frames. Ensures investigation or exclusions are consistent with a 'right to a fair trial'. Only board member informed of case in detail. Ensures a clear audit route has been established for tracking progress of the investigation, its' costs and resulting action. Representations may be made to the designated board member if these are not provided for by the Trust's grievance procedures.
Chair / Trust Board	Appoints a non-executive director as 'designated board member'. Collective responsibility for ensuring organisations internal procedures are being followed. Require a summary of each cases progress at the end of each exclusion period. Receives a monthly statistical summary of all exclusions, durations and number of times. Not informed in too much detail as they may be called upon to attend a hearing.
All doctors	Required to complete in full and as directed any templates or proformas as instructed, for use as part of this policy. Must co-operate with any requests from the NCAS. Where a practitioner may choose not to co-operate, this may necessitate disciplinary action and consideration of referral to the appropriate Regulatory Body.
National Clinical Assessment Service	A 'sounding board' for the Trust and provider of advice on all aspects of the process. Supplied with monthly statistical reports of exclusions at MHPS@ncas.nhs.uk. Issue Alert Letters.
Representative	A practitioner may be accompanied in any interview or hearing by a representative. The representative may be legally qualified but he or she will not be acting in a legal capacity. In

	addition to statutory rights under the Employment Act 2008, the representative may be another employee of the NHS Trust; an official or representative of the British Medical Association, or any other recognised trade union or a defence organisation; or a friend partner or spouse. In such cases' the representative may put the practitioner's case, sum up their case, respond on behalf of the worker to views expressed in the hearing and ask questions of the witnesses. They may not answer questions on the practitioners' behalf, address the hearing if the practitioner does not wish them to or prevent the investigating manager from presenting their case.
Policy Author	Responsible for ensuring the policy follows the appropriate Trust format and complies with the recognised development, consultation, approval and ratification process.

10 Associated Documents and References

10.1 ACAS (2015) Code of Practice Disciplinary and Grievance Procedures. Available at www.acas.org.uk

10.2 ACAS (2016) Discipline and grievances at work the ACAS guide. Available at www.acas.org.uk

10.3 Department of Health (2005) Maintaining High Professional Standards in the Modern NHS: A Framework for the Handling of Concerns about Doctors and Dentists. Available at www.ncas.nhs.uk

10.4 NHS Employers (2013) The Use of Settlement Agreements and Confidentiality Clauses

11 Monitoring compliance

11.1 The Trust's HR Business Partners will have responsibility for monitoring this policy.

11.2 The monitoring process includes:

11.2.1.1 Recording of all formal cases on ESR

11.2.1.2 Regular review of formal cases by HR Business Partners

12 Dissemination and Implementation

12.1 This policy will be made available on the intranet.