South East Coast Ambulance Service NHS
NHS Foundation Trust

Restriction in Clinical Practice Procedure

Contents

1 Scope

1.1. The South East Coast Ambulance (SECAmb) Service NHS Foundation Trust (the Trust) is committed to the provision of excellent clinical care to all those who access our service.

1.2. Healthcare is complex and involves risk. Organisations and individuals strive to provide safe and effective care but on occasion adverse events occur. Modern healthcare safety approaches look beyond simply of the actions of individuals and explores the systemic features of an event.

1.3. In the vast majority of incidents, staff can continue in their role while an investigation takes place and will be closely involved in the learning. This is evidence of a Just Culture, which the NHS describes as "*[just culture] encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way*". There are occasions however where the individual and/or Trust needs to apply temporary amendments to a member of staff's scope of practice in order to support an investigation or the staff involved.

1.4 The purpose of this procedure is:

- To promote a just and learning culture in the Trust.
- To protect patients and the public from the potential harm arising from healthcare accidents.
- To support staff involved in untoward events and to minimise instances of self-referral/ referrals to professional regulators (HCPC, NMC, GMC, GPhC).
- To develop organisational understanding of the nature of human error, analysis of incident, attribution of blame, and a learning and just culture.
- To work to optimise systems that prevent harm to patients and staff, and which are based on learning that involves staff.
- To reduce the use of restrictions, and where these are needed making restrictions fair, objective, and minimal; seeking to use these where the need is recognised and based on specific circumstances.
- To promote the public's trust and confidence in the ambulance service.
- To ensure consistency when engaging and communicating with professional regulators.

1.5. This procedure relates to all grades of clinical staff engaged in direct and indirect patient care in 111, 999 or other services delivered by the Trust.

1.6. Private Ambulance Providers' (PAP) staff are directly out of scope of this procedure. However, where concerns include PAPs, this will be managed within their own organisations, as detailed in our contracts with these organisations (with SECAmb oversight). Any actions should be in line with those taken within SECAmb and seek to ensure that staff are treated fairly and objectively, and in line with just culture principles.

1.7. This procedure sits directly under the Scope of Practice & Clinical Standards Policy. Restrictions in clinical practice must be considered in line with the risk assessment process appendices in the Disciplinary Policy and be undertaken in line with all the requirements outlined in this procedure.

1.8. An overarching principle of this procedure is that judgements about an individual's practice will only take place in the presence of balanced evidence upon which an objective assessment can be made, and restrictions will never be used as a control measure or in a punitive way.

2 Procedure

2.1. The Executive Medical Director is ultimately responsible for clinical care and professional practice. The task of considering and applying restrictions in clinical practice is delegated to the professional standards function within the Medical Directorate, led by the Consultant Paramedics (Urgent & Emergency Care) and the Professional Standards Managers (PSM). The decision should be discussed and agreed with professional standards, the employee's Operations Manager (or equivalent) or above, and their HR Business Partner before action is taken.

2.2. Cases involving other types of healthcare professions should include liaison between the Consultant Paramedic/PSM and the relevant professional lead (i.e., Chief Pharmacist, Executive Director of Nursing and Quality, Consultant Paramedic [critical care, education, etc.] and Executive Medical Director).

2.3. In all cases, consideration of safeguarding should be made, and the Safeguarding Consultant should be engaged within the decision-making process where necessary to provide assurance that our patients and staff are safeguarded.

2.4. Restriction in Clinical Practice is one of three options available to support investigations. The decision on which option to recommend should be based on the evidence, analysis and structured judgement agreed by the nominated senior leaders identified in this procedure. This should include as a minimum a consultant paramedic (urgent & emergency care) or

professional standards manager, a Human Resources Business Partner (HRBP), and a senior manager from the member of staff's team.

2.5. Prior to considering which route to take, analysis of the nature of the incident must be undertaken using a trust approved model (pending adoption of FAIR3) to minimise the risk of errors of attribution. (See appendix 2 **below** and appendix 3 **below** for FAIR3 model)

2.6. The three options are:

- Restriction in Clinical Practice (covered by this procedure)
- Suspension from duty (covered by the Disciplinary Policy)
- Remain on full duties while the investigation takes place (which may include temporary alterations to duties proportional to sanction).

2.7. The decision on which option is taken may be reviewed at any stage of the investigation and updated according to new information.

2.8. It should be borne in mind that the decision by the Trust to implement a restriction or to suspend a registered healthcare professional requires the professional to self-refer (or be referred) to the professional regulator (such as the Health & Care Professions Council [HCPC], Nursing & Midwifery Council [NMC] and the General Medical Council [GMC]), and so the decision must be carefully considered and agreed.

2.9. Investigators should follow the published guidance regarding the stage of an investigation where judgement can be applied. Restrictions (or suspension) should normally only be applied where sufficient balanced evidence has been gathered upon which a judgement can be made (See FAIR3 timeline in appendix 1 **below**).

2.10. In cases where evidence exists which strongly supports the need for restriction in practice (or suspension), the need to protect the staff member, patients and public must be the primary consideration above simply avoiding the need for the individual to self-refer to their regulator (where applicable). In cases where the evidence is weak, uncorroborated, and/or is otherwise subjective in nature, restriction should be avoided.

2.11. Self-referral should be undertaken within five working days of the notification of restriction in practice by the Trust, following the correct application of the procedure. Staff should seek support when preparing to, or are considering, self-referral to their professional regulator (PSD@secamb.nhs.uk).

2.11.1. When considering restriction (or other options), the information available should be assessed as part of an initial fact-finding process prior to the investigation commencing to ensure that where possible the incident occurred as described. This will assist with arriving at a proportional outcome (for example, a report made two years after an event, after which

no other report about the subject is made may suggest remaining in the workplace is appropriate). Investigators should seek advice from a Professional Standards Manager (PSM) to ensure that fact-finding is consistent and focused.

2.11.2. The restriction may reduce the level of stress or cognitive load on the clinician during any ongoing investigation. This underpins the fact that while a restriction may lead to the need to self-refer, the application of a restriction must only ever be regarded as a supportive act intended to support the member of staff. It should be remembered that self-referral does not mean automatic progression to a Fitness to Practice hearing and/or sanctions.

2.11.2.1. Fitness to practise is defined by the Health & Care Professions Council as "*[fitness to practise] is designed to protect the public from those who are not fit to practise*". Other professional regulators publish their own definitions and so individuals should refer to their own regulator for these specific definitions.

2.11.3. Staff who are subject to restrictions in their clinical practice have a professional obligation to notify any other employer (paid or voluntary) of their restriction. The Trust should always be aware of the secondary employment status of staff and may in certain circumstances opt to contact organisations where concerns regarding practice are such that organisational liaison is justified.

2.12. Any manager proposing restrictions in practice must ensure that any relevant HR policies and procedures are considered and followed, and general approach to good practice employee relations and legal compliance is maintained. An HR Business Partner, as well as a nominated professional lead (such as PSM or consultant paramedic), must be consulted in any instances where a manager is proposing a restriction in practice. Staff should be invited to speak to their nominated representative at an early stage.

2.13. The proposal for any restriction to a clinician's practice must be made via either an Assistant Operations Director (ADO) (or appropriate delegated deputy such as an Operating Unit Manager [OUM]), or appropriate Senior Operations manager in 111/EOC (or delegated deputy) to a Consultant Paramedic (or delegated deputy, such as a professional standards manager).

2.14. A delegated deputy to the regional or senior operations manager should be a manager within the Operations Directorate at band 8b or above, with prior authorisation to agree to any restriction in practice proposal.

2.15. A delegated deputy to the Consultant Paramedics should be a Professional Standards Manager or, where this isn't possible, another senior clinical lead within the Medical Directorate working as a direct

report to a Consultant Paramedic or the Executive Medical Director and have prior authority to approve a proposed restriction in practice.

2.16. The decision to suspend a clinician's practice whether registered or unregistered must be supported by the Executive Medical Director (at the time at or soon as reasonably practicable).

2.17. In the absence of a Consultant Paramedic or Professional Standards Manager (PSM), the Strategic Clinical Advisor may, where they feel there is a risk to patient safety and based on an objective assessment of accountability and available evidence, temporarily restrict the duties of the clinician. This must be reviewed by the Consultant Paramedic at the earliest opportunity.

2.18. The Consultant Paramedic/PSM concerned will examine the circumstances around the incident, the rationale for the proposed restriction and if there is a requirement for any restriction to be put into place. The Trust's decision support tool (FAIR3) should be used to objectively assess the type of issue (i.e., error or violation), apply the "special tests" and agree on the level of accountability based on the evidence available (see Appendix 1 **below**). The decision to apply a restriction should be agreed or rejected with the ADO/delegated deputy responsible. Any agreed decision to restrict practice should focus on the follow considerations.

2.18.1. The Trust considers suspension and restriction in clinical practice as a neutral act but accepts that, for HCPC registrants, it leads to the requirement to self-refer. Consideration should be given to the most appropriate measure following an incident or allegation to ensure unnecessary referrals are avoided.

2.18.2. This decision will be made, as far as practicably possible, following the gathering of evidence which is balanced and objective and avoids a reactive application of blame.

2.18.3. Any restriction in practice in place will be regularly reviewed whilst an investigation is ongoing. Fact-finding may include formal or informal interviews, seeking statements, or reviewing available evidence (i.e., CCTV or CAD notes). The member of staff should be kept appraised of the investigation and be assured that the circumstances are being investigated systemically, rather them being the focus of the investigation.

2.18.4. Where the allegations lack very clear evidence (for example, an isolated report), or there is suspicion of a vexatious situation, consideration will be given initially to avoiding restriction (or suspension) as this will avoid the need to self-refer.

2.19. The following wording should be considered in light of incidents requiring actions following consideration of the evidence at that stage of the investigation.

2.19.1. Restriction in Clinical Practice: The clinician's scope of practice is altered to reduce their authority to carry out a full range of clinical duties and care. This must be proportionate to the issue being investigated and not be "blanket" in nature.

2.19.2. Suspension from duty: A neutral act which allows investigations to take place while the clinician is not in the workplace. Where applicable in instances where a clinician may work in more than one role and / or for another employer, this may be accompanied by a restriction in clinical practice or applied in isolation depending on the prevailing situation.

2.19.3. Where the registrant is employed in another healthcare setting it is the responsibility of the employee/registrant to inform the alternative employers of restrictions in clinical practice, where it is in the 'interests of patient safety and public protection'. This overrides the requirement to maintain confidentiality.

2.19.4. Remaining in the workplace while the investigation is conducted (which may include "Temporary Operational Redeployment" to support the member of staff, but which falls short of restriction. (For example, asking the clinician to not work on a Single Response Vehicle until the incident is resolved). n.b. where deployment on a double crewed vehicle is used to provide direct supervision, this constitutes a restriction which triggers the requirement to self-refer to the HCPC (other regulators guidance should be reviewed as necessary).

2.20. **Responsibility for imposition of Restrictions of Clinical Practice**

2.20.1. The decision to impose restrictions in clinical practice can only come from an ADO or delegated senior operational deputy, with advice and oversight from a Consultant Paramedics (or delegated deputy). This should be an increasingly rare event in a trust which has an emerging and maturing Just Culture. On this basis, careful application of this procedure should be followed.

2.20.2. This process should include early consideration of support from wellbeing, unions, etc in line with the disciplinary policy and procedure.

2.20.3. The decision to impose a restriction cannot be overturned on the basis of the resourcing requirements of operational deployment. Patient safety must take precedence.

2.20.4. Once the decision has been made that a restriction is necessary, the person or persons involved must be verbally informed of this decision by the either the ADO or delegated senior operational deputy.

2.20.5. At the point of restriction, it must be made clear why this decision has been made, the exact nature of restriction and its direct and proportionate relationship with the circumstances of the investigation. Where possible by giving details of the amended scope of practice and the ADO or delegated senior operational deputy subsequently writing to the individual within five working days of the meeting to restrict an employee.

2.20.6. It is the responsibility of the ADO or delegated senior operational deputy to inform both the Operational Management Team and Scheduling department of the restriction. This must be done on the same day as the restriction is imposed. This may be done verbally but must be followed by an email to the relevant Operational and Scheduling management team as soon as possible.

2.20.7. If an extension to the restriction is required the member of staff concerned must be informed as soon as possible verbally and followed up in writing by the ADO, delegated deputy, or Consultant Paramedic and this must be supported in writing as soon as practicable within five working days.

2.21. Levels of Restriction of Clinical Practice

2.21.1. Normal practice will be to restrict the clinician to work with another member of staff at the same or preferably higher clinical grade in order to provide direct supervision of their practice. It may be necessary to reduce a clinician to working at a lower graded role depending on the nature of the incident of which they have been involved (i.e., Paramedic to Technician). Dependant on the specific role of the person in question and the specific issues that the restriction is designed to provide protection for, individual terms of restriction may vary.

2.21.2. Restriction of registrants to a lower clinical grade does not affect their obligations as a registrant and is only a reflection of an alteration to the authority to practice by the employer.

2.21.3. Restriction of clinical practice is not punitive and therefore individuals working within the terms of a restriction will continue to be paid at their normal rate.

2.21.4. When making the decision to implement restrictions in practice, the ADO/delegated deputy and Consultant Paramedic should be mindful of imposing the least possible amount of restriction while still being able to offer appropriate protection for patients, staff, and the Trust’s reputation.

2.21.5. If required, a review of the restriction will take place by the ADO/ delegated senior operational deputy in conjunction with the Consultant Paramedic and in consultation with the relevant HR Business Partner after a period of 14 days (or sooner if the conditions/circumstances change). The member of staff under restriction should be informed in writing from

the OUM or delegated senior operational deputy of extensions to the restriction in practice and the reason for the extension.

2.22. Reporting Restrictions of Clinical Practice

2.22.1. Registrants who have had their practice restricted must report the restriction to their regulating body within five working days of the restriction being placed (where the specific regulators published standards require this).

2.22.2. If this is not done, a Professional Standards Manager, on behalf of the Trust, may report the restriction in writing to the relevant regulator.

2.22.3. A Consultant Paramedic or relevant alternative professional lead (i.e., pharmacist, nurse) should ensure that the relevant registered authority has been informed.

2.23. Lifting of Restrictions of Clinical Practice

2.23.1. Restrictions may be lifted in the following circumstances:

- If before an investigation is completed, evidence comes to light that negates a suspension or restriction, should there be an expedited process to remove or downgrade the restriction.
- On completion of the investigation, if it is found that there is no action to be taken.
- On completion of any disciplinary hearing convened and the issue of any formal disciplinary warning as a result of the incident or circumstances that initiated the restriction.
- On successful completion of any educational requirement recommended as a result of the incident or circumstances that initiated the restriction. Any training requirement should be applied in line with just and learning cultures and not infer blame.
- On successful completion of any supervisory activity described in any action plan.
- Responsibility for lifting the restriction lies with the ADO or delegated senior operational deputy in conjunction with a Consultant Paramedic. A formal letter should be sent to the member of staff as soon as the restriction is lifted.

2.24. Engagement and Communication with Professional Regulators

2.24.1. All referrals to the HCPC or other professional regulator should only take place following liaison with a Professional Standard Manager (PSM) who

will liaise with relevant professional leads. This applies to referrals being made by the Trust regarding a registered employee, or individual registrants considering self-referral. This will ensure that referrals are appropriate and consistent and will also ensure that staff are supported from the earliest stages of any issues relating to registered professional practice.

2.24.2. After a referral is made, the regulators will maintain contact with usually the investigating manager, the commissioning manager or HR department. Anyone receiving communication from regulators should copy in the Professional Standards team to any subsequent communication (PSD@secamb.nhs.uk). This will ensure that PSD have an overview of cases and will facilitate early intervention or support from the Professional Standards team.

2.24.3. Trust managers who are chairing disciplinary hearings should liaise with PSD to discuss the requirements for referral/self-referral for cases where the outcome may require this.

2.24.4. Any request from a professional regulator for Trust documentation to support a Fitness to Practice (FTP) investigation/hearing should be actioned by the HRA/HRBP supporting the Trust investigation. PSD should also be copied into any communication in order to maintain an overview of contact with the regulator and provide advice and support where necessary. Documentation should be unredacted unless there are specific disclosure concerns. (These concerns would need to be discussed with the regulator on a case-by-case basis and the Trust's Legal Service Team may also be required to assist in these cases). Guidance issued by the HCPC includes specific reference to the legislation which supports information sharing regarding FTP investigations:

"Article 25(1) of the Health and Social Work Professions Order 2001 gives us the power to require an organisation to provide us with information relevant to fitness to practise allegations. There are some exceptions to this power, listed in the Article from paragraph (3) – (5). You can find a copy of the order at www.hcpc-uk. org/about-us/corporate-governance/legislation This power overrides the General Data Protection Regulation 2018 and other data protection safeguards, such as Caldicott Guardian arrangements."

3 Responsibilities

3.1. The **Executive Medical Director** will have overall responsibility for the restriction of any member of staff's clinical duties and may choose to increase, decrease, or remove any restriction that has been put into place.

3.2. **All clinical staff** of the Trust have a responsibility to act within their scope of practice and the codes of conduct, policies and procedures laid down by the Trust and where appropriate the Health and Care Professions

Council (HCPC) or other professional body. Staff placed on restriction have a responsibility to inform the Emergency Operations Centre (EOC) Manager at the commencement of their shift.

3.3. **Assistant Directors of Operations (ADO) (or nominated deputy)** have the responsibility to ensure, that where appropriate any restriction to clinical practice should be fairly applied according to this procedure and all other policies and procedures within the Trust. They must inform staff that work with clinicians on the scope of restriction and the responsibilities they are expected to carry out whilst in this supervisory role. The senior manager also has responsibility to notify the Professional Standards Department (PSD) and the Scheduling Managers of the restriction.

3.4. **Operational Managers (111 Leads/ PSM/PDL/ CCPTL/ CCPOM/ OUM/ OM/ OTL/ HART TL)** have the responsibility to ensure, that where appropriate, investigations into clinical errors, omissions or violations in policy and procedures are carried out in accordance with this procedure.

3.5. **Supervising Staff.** Staff that have been asked to work with someone who is under clinical restriction must monitor and provide support to the member of staff under restriction. Whilst it is understood that the member of staff who is under restriction retains responsibility for their own actions, every effort should be made by the clinician they are working with to ensure patient safety.

3.6. **Consultant Paramedics (urgent & emergency care)** and **Professional Standards Managers** have the responsibility for monitoring and overseeing any implementation of any restriction in clinical practice and working with the ADOs or nominated deputy for the lifting of the restriction when appropriate.

3.7. **Scheduling Department** will ensure that the appropriate grade of staff work with the member of staff on restriction. The Scheduling Manager(s) will enter appropriately the restriction on the register within Global Rostering System (GRS). The word “restriction” should not be available to members of staff within the scheduling department.

4 Audit and Review (evaluating effectiveness)

4.1. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

4.2. Effectiveness will be reviewed using the tools set out in the Trust’s Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

4.3. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced,

or if feedback from employees indicates that the policy is not working effectively.

4.4. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

5 References

5.1. Health and Care Professions Council Standards of Proficiency

5.2. Health and Care Professions Council Standards of Education and Training

5.3. Health and Care Professions Council Standards of Conduct, Performance and Ethics

5.4. See extract from the HCPC as an example below along with links to the codes of conduct for all of the relevant professional bodies.

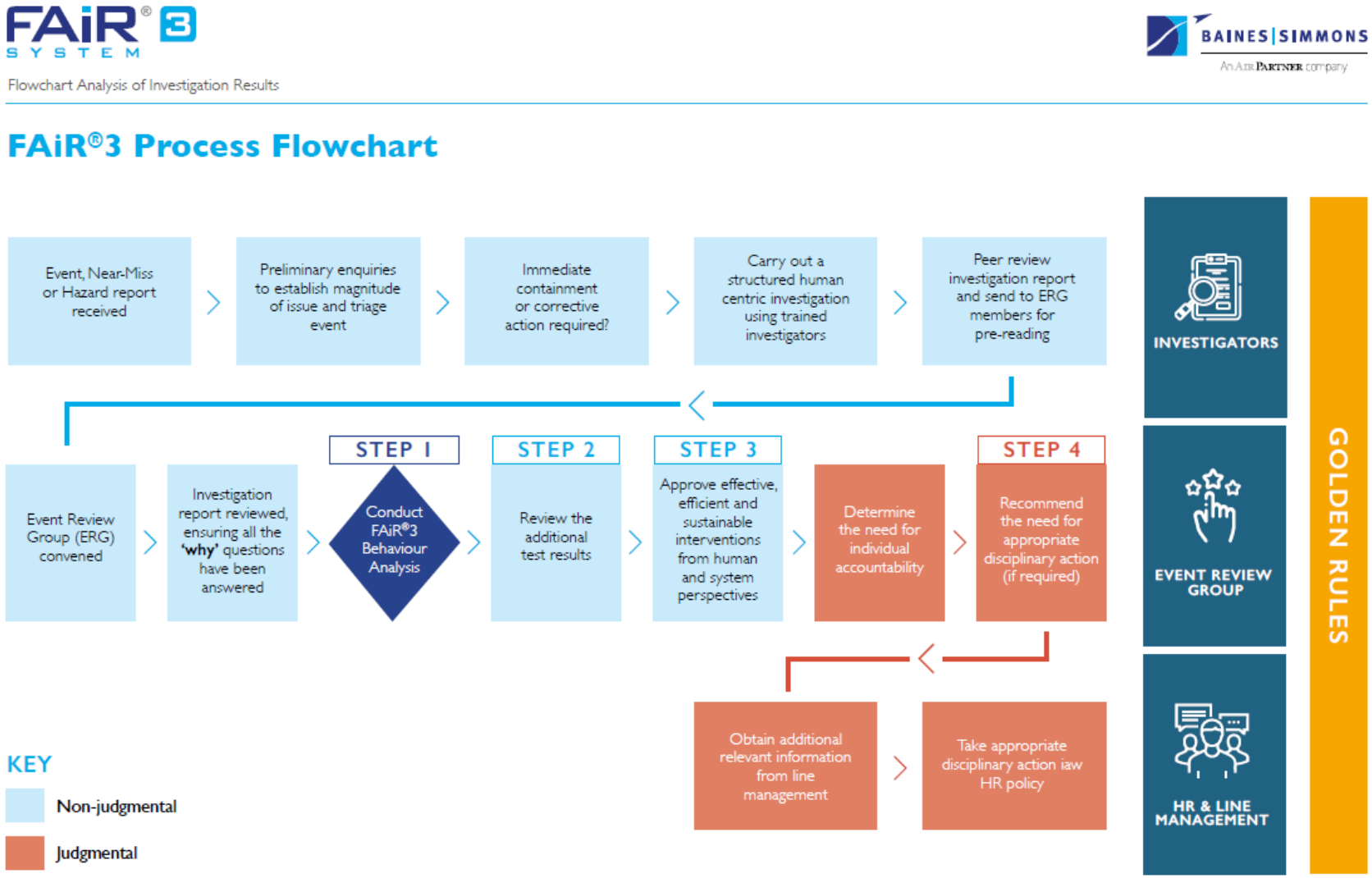
The standards of conduct, performance and ethics say that:
"You must tell us (and any other relevant regulators) if you have important information about your conduct or competence, or about other registrants and health and care professionals you work with. In particular, you must let us know straight away if you are:

- *convicted of a criminal offence, receive a conditional discharge for an offence, or if you accept a police caution;*
- *disciplined by any organisation responsible for regulating or licensing a health or social care profession; or*
- *suspended or placed under a practice restriction by an employer or similar organisation because of concerns about your conduct or competence.*

5.5. **Other professional regulators codes and standards are listed below.**

- https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
- https://www.hcpc-uk.org/resources/standards/standards-of-proficiency-paramedics/
- https://www.hcpc-uk.org/standards/standards-of-proficiency/physiotherapists/
- https://www.nmc.org.uk/standards/code/
- https://www.gmc-uk.org/about/how-we-work/governance/council/code-of-conduct
- https://www.pharmacyregulation.org/sites/default/files/standards_for_pharmacy_professionals_may_2017_0.pdf

Appendix 1: Baines-Simmons FAIR3 model (judgement process flowchart)



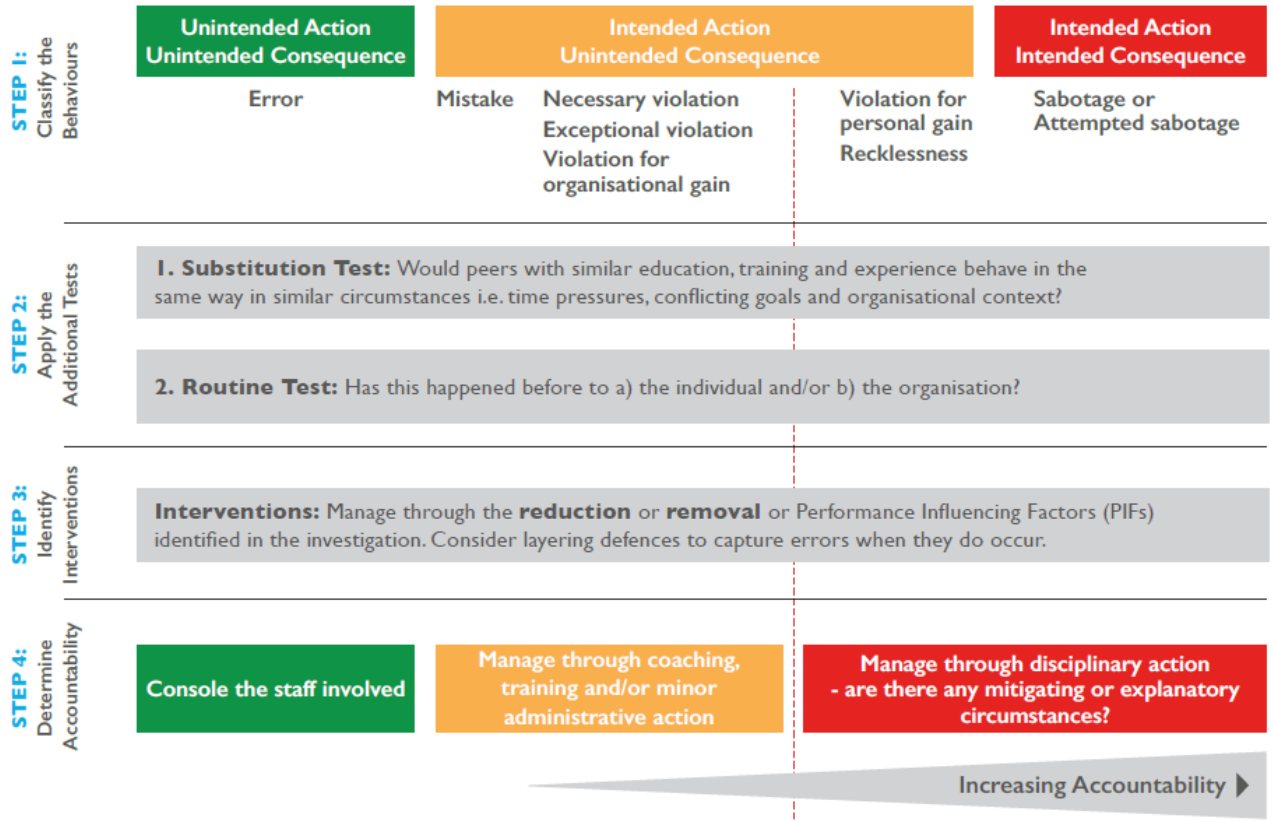
Appendix 2: Baines-Simmons FAIR3 model (accountability and special tests)

FAiR® 3 SYSTEM

Flowchart Analysis of Investigation Results

BAINES|SIMMONS An AIR PARTNER company

STEP 4: Determine Accountability (continued)



Appendix 3: Restriction in Practice Discussion Record Form

Proposed Restriction in Clinical Practice Discussion Record Form		
		Notes
Case Reference:		
Name of subject of proposed restriction:		
Clinical Grade:		
Location:		
Name of Line Manager		
Name of HR Business Partner:		

		Notes (i.e., name of deputies)
Consultant Paramedic (or PSM)		
Assistant Director of Operations (ADO) (or delegated OUM)		
Date of Discussion		
Outline of case presented by ADO/OUM		
Key points raised and discussed		
Structured analysis of accountability and evidence reviewed (using FAIR3)	(Yes/No) Comments	
Agreed outcome:		Rationale
	Restriction (include details of restriction in rationale column)	
	Recommend suspension from the workplace	
	Remain in the workplace (include any welfare or other pertinent notes)	
Date outcome effective from		
First review date		
Confirm submission to HRBP and HR Admin Lead		

Instructions:

- ADO/deputy to save to secure location and share with HRBP
- Consultation Paramedic to receive copy (in PDF format) which should be passed to Executive Medical Director as necessary
- OUM to liaise with local line management to implementation agreed actions arising from the discussion
- Copy to be retained by line management in member of staff's P File