Livewell Southwest

Maintaining High Professional Standards Policy

Version No 3:3

Review: June 2017

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The policies and procedures page of Healthnet holds the most recent and procedural version of this guidance. Staff must ensure they are using the most recent guidance.

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Asset Number: **257**

Reader Information

Title	Maintaining High Professional Standards Policy.V.3.3
Information Asset Register Number	257
Rights of Access	Public
Type of Formal Paper	Policy
Category	HR
Subject	Process for managing concerns regarding the performance of senior medical and dental staff
Document Purpose and Description	Guidance for all senior medical and dental staff on managing concerns regarding the performance of senior medical and dental staff
Author	Medical Director, Livewell Southwest
Ratification Date and Group	Local Negotiating Committee – 20 June 2016
Publication Date	21 June 2016
Review Date and Frequency of Review	One year after publication, or earlier if there is a change in evidence
Disposal Date	The PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule, all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job Title of Person Responsible for Review	Medical Director, Livewell Southwest
Target Audience	Senior medical and dental staff (excluding doctors in training and non-medical staff)
Circulation List	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the PRG Secretary on 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation Process	Consultation with LNC
Equality Analysis Checklist completed	Yes
References/Source	Maintaining High Professional Standards in the Modern NHS – Secretary of State for Health – February 2005
Supersedes Document	All previous versions
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Document Review History

Version No.	Type of Change	Date	Originator of Change	Description of Change
1	First full review			New document
2	Full review	February 2006	Teresa Duggan: Medical Staffing Officer,	Revised version
2:1	Updated draft	27/02/2006	Jade Brelsford: Deputy Manager, Public Information Service	Redrafted to meet with corporate standards.
2:2	Extended	June 2013	PRG Secretary	Extended, no changes.
3.	Full review	September 2013	Medical Director	Revised version
3.1	Extended	October 2015	Deputy Head of HR	Extended no changes
3.2	Extended	March 2016	HR Manager	Extended and updated to LSW.
3.3	Reviewed	June 2016	Medical Staffing	Minor updates

Maintaining High Professional Standards Policy

1. Introduction

1.1 This is an agreement between Livewell Southwest (LSW) and the Local Negotiating Committee (LNC) outlining LSW's policy for handling concerns about doctors' and dentists' conduct and capability. It implements the framework set out in "Maintaining High Professional Standards in the Modern NHS".

1.2 This policy may be amended to reflect any future national advice or guidance but only by agreement with the LNC. Where there is any conflict or lack of clarity the existing national agreed guidance will take precedence. The operation of the procedure in practice will be reviewed after two years from the date indicated at the end of the document.

2. General policy

2.1 LSW, recognising the honesty and integrity of its staff, believes that personal and professional conduct should largely be self-regulated.

2.2 LSW accepts that breaches of the rules of conduct and standards of performance will occur from time to time. LSW expects managers to deal with these breaches firmly but with sensitivity and in accordance with this Policy or LSW Disciplinary Policy. Breaches should, wherever appropriate, be dealt with informally in the first instance. This is particularly so in the case of medical and dental staff where a number of mechanisms exist for potential problems to be addressed by the profession at an early stage on a colleague-to-colleague basis.

2.3 Where formal disciplinary action is used, it should emphasise and encourage improved standards of performance/conduct and employee effectiveness. It is not merely a means of punishment.

2.4 This Policy is consistent with the ACAS Code of Practice 'Disciplinary Practice and Procedures in Employment'. Recognition of this is particularly important because, in any proceedings before an Employment Tribunal, adherence or otherwise to the principles of the Code of Practice can be admissible in evidence.

2.5 Practitioners who are subject to the procedures in this document will be provided with a summary of rights (see Appendix C). Practitioners have the right to be represented and/or accompanied by an accredited representative of a trade union or a workplace colleague.

2.6 It is a principle of these procedures that when appropriate, issues are dealt with by the immediate clinical line manager of the practitioner.

2.7 It is recognised that it may be appropriate on occasions after consideration by the Medical Director, Deputy Head of HR or Chief Executive (hereafter referred

to as MD, DHHR and CE) to inform the General Medical Council (GMC), National Clinical Assessment Service (NCAS) and other outside agencies about issues dealt with under these procedures.

2.8 These procedures apply to all Medical and Dental staff employed by LSW. Medical and Dental staff who hold honorary contracts with LSW and undergraduates will also be subject to these procedures. Where disciplinary action is contemplated, and the issue relates to a doctor in training, then the Post Graduate Medical Dean's offices should be informed via the Associate Medical Director for Post Graduate Medical and Dental Education.

2.9 Where, within these procedures, an issue is referred to the MD and DHHR or nominated deputies it is understood that the MD or nominated deputy has the responsibility for making the final decision after seeking advice.

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

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

2.11 Unfounded and malicious allegations can cause lasting damage to a practitioner's reputation and career prospects. Therefore all allegations must be properly investigated to test their veracity.

2.12 LSW will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of any of the protected characteristics covered by the Equality Act 2010.

2.13 Staff involved in investigating capability or conduct concerns must be appropriately qualified and have undergone Equality and Diversity training

2.14 This Policy has been developed in line with the Department of Health (DoH) 2005 national guideline 'Maintaining High Professional Standards in the Modern NHS', the National Clinical Assessment Service (NCAS) 2010 good practice guides 'The Back On Track framework for further training' and 'How to Conduct a Local Performance Investigation'.

2.15 The Policy provides a number of processes which allow for the most appropriate and proportionate action to be taken depending on the circumstances of the case.

2.16 This Policy should be read in conjunction with the LSW's Medical Appraisal Policy and in conjunction with the Equality Act 2010.

2.17 All medical and dental staff have a professional and contractual responsibility to perform their duties to an acceptable standard as set out by the General Medical and General Dental Council and the Royal College/Specialty Association as applicable.

2.18 The Organisation has a duty to support and enable senior doctors and dentists to achieve these standards. This includes providing appropriate remedial resources and support when concerns are identified.

2.19 All concerns should be dealt with in a manner proportionate to the level of concern. All concerns should be considered on the information available and where possible managed informally between the practitioner and their line manager. Consideration must be given to the necessity of informing the CD, Locality Manager or DDHR.

2.20 Serious concerns must be raised with the MD, who will register the concerns with the CE. Serious concerns should be fully investigated in a timely manner.

2.21 When serious concerns are raised about a practitioner consideration should be given to whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or exclude the practitioner from the workplace. See Section 8 plus Appendix D.

2.22 A clear audit route must be established for initiating and tracking progress of all actions taken, both informally and formally.

2.23 If at any point in the process, the case manager considers the practitioner to be a potential or actual risk to patients or staff, the practitioner must be referred to the regulatory body. In the first instance this may include requesting advice from the regional GMC ELA. In high risk situations, consideration should also be given to the necessity of issuing an alert letter to other health agencies where the practitioner may have clinical duties.

2.24 At all formal stages the practitioner must be offered the right to representation and support. This can be by a Trade Union representative and/or work colleague.

2.25 At any stage of the handling of a case, consideration should be given to the involvement of external agencies for information, advice and support. These may include NCAS, GMC ELA, Royal Colleges or Specialty Associations. If a formal referral to NCAS is required this will be made by either the MD or CE.

2.26 Management of some cases may require the Organisation to consult with employment law specialists

2.27 Any timescales referred to in this Policy are calendar days.

3. Definitions and roles

3.1 Case Manager

The person responsible for reviewing the information available, assessing the facts and identifying the most appropriate action based on the processes set out in this Policy. The MD will act as case manager in cases involving clinical directors and leads, but may delegate this role to a senior clinical manager in other cases. This is most likely to be the Clinical Lead or Clinical Director

3.2 Designated Member

A non-executive director who oversees the case to ensure that momentum is maintained. Appointed by the Chairman of the Board

3.3 Case Investigator

The person(s) identified to lead the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The MD is responsible for appointing a case investigator. The case investigator must formally involve a senior member of the medical or dental staff where a question of clinical judgment is raised during the investigation process.

3.3.1 The case investigator needs to be appropriately qualified and must ensure strict confidentiality. Patient confidentiality needs to be maintained but the investigation report needs to clearly show the details of the allegations.

3.3.2 It is the responsibility of the case investigator to judge what information needs to be gathered and how.

3.3.3 The case investigator needs to ensure that sufficient evidence is collected to fully consider all aspects of the investigation and that a report is made of the investigation process and the information gathered.

3.3.4 Decisions regarding actions required at the completion of the investigation are not made by the case investigator

3.3.5 The case investigator may not be a member of a disciplinary or appeal panel subsequent to the investigation

4. Informal procedure

4.1 As a general principle, it is expected that minor issues of minor misconduct or performance will be dealt with by the immediate clinical line manager of the practitioner without resort to the MD. In such circumstances, it may or may not be appropriate for the MD to be informed of the outcome.

4.2 If a matter is reported to the MD, then he/she has the discretion to informally investigate the issue which may include the setting up of a small panel of up to three appropriate medical practitioners/medical managers. Where the matter involves specialist expertise not available within LSW the MD may appoint (and the practitioner may request) an additional external practitioner with that expertise who is acceptable to both the MD and practitioner under investigation. If appropriate this person's contribution may be by telephone, email or letter. The above approach can be utilised for the full range of issues including those of potential harassment and bullying. If at a later stage it is considered by the MD or deputy that there is a case to answer of sufficient gravity, these issues will then pass over to the appropriate LSW policy following discussion with the DHHR. The appropriate LSW Policy could include e.g. Bullying and Harassment (Respect and Dignity at Work), Disciplinary Policy and Procedure. In such event the report of the informal investigatory panel may be used as all or part of the preliminary investigation referred to in the formal process under paragraph 5.

4.3 The purpose of this informal; investigation is to provide the MD with sufficient information to make an informed decision.

4.4 If the MD chooses to adopt the informal procedure the practitioner in question will be informed of this fact in writing together with details of the issue under investigation. Following the informal investigation the practitioner will be provided with the summary of findings and recommendations of the investigatory panel and will be invited to a meeting if necessary. In any event the practitioner will be advised in writing that;

i. There is no case to answer and no further action, or

ii. That the matter will be investigated in accordance with the appropriate formal procedure, or

iii. The details of the MD's proposals for resolving the matter as an alternative to following the appropriate formal procedure. This may include remedial supportive action, further training or modification of responsibility, job plan review, referral to the Occupational Health and Wellbeing department, issuing formal verbal or written warning by the MD or CE. The appropriate formal procedure will be followed in the event that the practitioner does not agree to the MD's proposals in this regard. The matter will ideally be considered within two weeks of the MD advising the practitioner in writing as described above.

5. Formal procedure

5.1 **Preliminary Investigation**:

5.1.1 Allegations or complaints made by any person about a member of the Medical or Dental staff of LSW which have not been resolved by the immediate clinical line manager, will be made available to the MD. If the MD agrees that the matter cannot be resolved by the immediate clinical

line manager, he/she will after consultation with the DHHR decide whether or not to commission a preliminary investigation under this formal procedure or deal with the matter informally as set out in paragraph 4 above. This preliminary investigation may be conducted by setting up an internal panel whose members will be nominated by the MD as in paragraph 4.2 above.

5.1.2 Upon completion of the preliminary investigation a report will be made to the MD who (following consultation with the DHHR) will make recommendations to the CE. These recommendations may include:

i. That there is no substance in the allegation, no case to answer and no further action required.
ii. The matter needs further investigation required under the appropriate LSW Procedures. Under these circumstances the NCAS will be consulted.
iii. Remedial supportive action, which may include further training or modification of responsibilities, job plan review, referral to the occupational health department, issuing formal verbal or written warning by the MD or CE. The appropriate formal procedure will be followed in the event that the practitioner does not agree to the MD's recommendations in this regard.

5.1.3 Under ii above the investigatory team will report back to the MD. The MD on advice from the DHHR will decide the appropriate course of action and if necessary the classification of the alleged complaint.

5.2 The practitioner is notified in writing the outcome of the alleged allegation.

5.3 In all cases the person making the complaint/allegation(s) should be informed of the conclusion reached by the MD and the action that has been taken.

6 Case investigations

6.1 The purpose of the investigation is to ascertain the facts in an unbiased manner. The case investigator has wide discretion on how the investigation is carried out.

6.2 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.

6.3 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, the name of the case investigator and made aware of the specific allegations or concerns that have been raised (see Appendix B). 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

6.4 At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body; an official or representative of the British Medical Association [any other recognised trade union], British Dental Association or a defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity. (See Appendix C)

6.5 The investigation is intended to gather factual information about the practitioner's performance in order to confirm or refute allegations or concerns raised. Information regarding team, directorate and organisational factors which may influence performance should also be sought.

6.6 If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider whether an independent practitioner from another healthcare body should be invited to assist. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional misconduct, the case investigator must obtain appropriate independent professional advice.

6.7 When interviewing staff, the investigator should remain objective and avoid leading the witness through inappropriate feedback or comment. At the end of the interview the practitioner should be asked if there is anything else that they wish to add to the evidence that they have given. Following the interview, practitioners should be given written details and asked to confirm that it is an accurate record of their interview.

6.8 Having collected the evidence the investigator should set out the facts as they see them, weighing the evidence on the balance of probabilities. The more serious the concern about the practitioner, the greater is the need for the investigators to satisfy themselves that the evidence supports their findings of fact.

6.9 The case investigator should complete the investigation within 20 working days of appointment and submit their report to the case manager within a further five working days. The case manager must give the practitioner the opportunity to comment on the factual content of the report produced by the case manager. The comments must be submitted in writing to the case manager within 10 working days of receipt.

6.10 Where an investigation establishes a suspected criminal action in the UK or abroad, this will be reported to the police. LSW will consult with police to ensure that both investigations can run concurrently without any impediment or obstruction to either. In cases of fraud, the Counter Fraud and Security management service will be contacted.

7 Identifying if there is a problem

7.1 The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with the DHHR, the MD and the National Clinical Assessment Service (NCAS). NCAS asks that the first approach to them should be made by the CE or MD.

7.2 The case managers should explore the potential problem with NCAS to consider different ways of tackling it themselves, possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than NCAS.

7.3 The case manager should not automatically attribute an incident to the actions, failings or acts of an individual alone. Root-cause analyses of adverse events should be conducted as these frequently show that causes are more broadly based and can be attributed to systems or organisational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions. The National Patient Safety Agency (NPSA) facilitates the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses and the case manager should consider contacting the NPSA for advice about systems or organisational failures.

7.4 Having discussed the case with the NCAS and/or NPSA, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen NCAS should still be involved until the problem is resolved.

7.5 Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the MD must, after discussion between the CE and DHHR, appoint an appropriately experienced or trained person as case investigator. The seniority of the case investigator will differ depending on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained, to enable them to carry out this role when required.

7.5.1 The case investigator:

- Is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings;
- Must formally involve a senior member of the medical or dental staff where a question of clinical judgment is raised during the investigation process. (Where no other suitable senior doctor or dentist is

employed by LSW a senior doctor or dentist from another healthcare body should be approached);

- Must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but 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;
- Must ensure 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;
- Must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the MD and DHHR;
- Must assist the designated Board member in reviewing the progress of the case.

7.6 Involvement of the NCAS following Local Investigation

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

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

- Performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk;

- Alternatively or additionally, problems that are ongoing or (depending on severity) have been encountered on at least two occasions.

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. NCAS may advise on this.

7.6.3 Where LSW is considering excluding a doctor or dentist (whether or not his or her performance is under discussion with NCAS), LSW will inform NCAS of this at an early stage, so that alternatives to exclusion are

considered. Procedures for exclusion are covered in Section 8 of the policy. 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.

7.6.4 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 NCAA[S] 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").

7.6.5 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 or dentist 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 or GDC.

7.7 Confidentiality

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

7.7.2 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. LSW will operate consistently with the guiding principles of the Data Protection Act.

8. Process for exclusion

8.1 In this part of the policy, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of the fitness to practice hearing.

LSW must ensure that:

- Exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
- Where a practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
- All extensions of exclusion are reviewed and a brief report provided to the CE and the Board;

- A detailed report is provided when requested to the MD who will be responsible for monitoring the situation until the exclusion has been lifted.

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

Where the practitioner is a Clinical Academic employed by the University of Plymouth, consultation will take place with the Head of Department of the practitioner prior to any action taken under this section unless there is an immediate threat to patient safety.

8.2 The purpose of exclusion is to protect the interests of patients or other staff and/or to assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

It is imperative that exclusion from work is not misused or seen as the only course of action that could be taken.

The degree of action must depend on the nature and seriousness on the concerns and on the need to protect patients, the practitioner concerned and/or their colleagues.

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

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

8.4 In cases relating to the capability of a practitioner, consideration should be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach should be sought from 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 NCAS, which can assess the problem in more depth and give advice on any action necessary. NCAS can offer immediate telephone advice to case managers considering restriction of practice or exclusion and, whether or not the practitioner is excluded, provide an analysis of the situation and offer advice to the case manager.

8.5 Key Features of Exclusions from Work:

- An initial "immediate" exclusion of no more than two weeks if warranted

- Notification of NCAS before formal exclusion
- Formal exclusion (if necessary) for periods up to four weeks
- Advice on the case management plan from NCAS
- Appointment of a Board member to monitor the exclusion and subsequent action
- Referral to NCAS for formal assessment, if part of case management plan
- Active review to decide renewal or cessation of exclusion
- A right to return to work if review not carried out
- Performance reporting on the management of the case
- Programme for return to work if not referred to disciplinary procedures or Performance assessment.

8.6 Immediate Exclusion

An immediate time limited exclusion may be necessary for the purposes identified in the above paragraph following:

- A critical incident when serious allegations have been made
- There has been a break down in relationships between a colleague and the rest of the team
- The presence of the practitioner is likely to hinder the investigation
- Allegations of criminal acts.

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

8.7 Formal Exclusion

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. It is the case manager who excludes the practitioner. 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.

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

- The allegation appears unfounded

- There is a misconduct issue
- There is a concern about the practitioner's capability
- 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.

Formal exclusion of one or more clinicians must only be used where:

a) There is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:

   - Allegations of misconduct
   - Concerns about serious dysfunctions in the operation of a clinical service
   - Concerns about lack of capability or poor performance of sufficient seriousness that it is warranted to protect patients

b) The presence of the practitioner in the workplace is likely to hinder the investigation.

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.

When the practitioner is informed of the exclusion there should, where practical, be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to NCAS with voluntary restriction).

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 four weeks), the content of the allegations, the terms of the exclusion, and that a full investigation or what other action will follow. The practitioner and their companion should be advised that they may make representations about the exclusion to the designated board member at any time after receipt of the letter confirming the exclusion ***and to ensure Human Rights Laws are not transgressed***.

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. ***Extension of formal extension should also be confirmed in writing as soon as possible.***

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 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 "renew ability" must be adhered to and any further exclusion be confirmed in writing to the practitioner.

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 the NHS Commissioning Board and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

There are no other forms of exclusion other than those laid down in this policy.

8.8 **Exclusion from the Premises**

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

8.9 **Keeping in Contact**

Exclusion under this policy will usually 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 will 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).

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 and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

8.10 Informing Other Organisation's

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

Where the case manager believes that the practitioner is practising in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, he or she should contact the professional regulatory body and the Medial Director of the Regional Office of the NHS Commissioning Board to consider the issue of an alert letter.

8.11 Keeping Exclusions under Review

8.11.1 Informing the Board

The Board must be informed about exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed. It should, therefore:

- require a summary of the progress of each case at the end of each period of exclusion, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible;

- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the NHS Commissioning Board.

8.11.2 Regular Review

The case manager must review the exclusion before the end of each four week period and report the outcome to the CE and the Board. In the case of a Clinical Academic, the report should also be copied to the university Head of Department. This report is advisory and it would be for the case manager to decide on the next steps as appropriate. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

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. 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.

8.11.3 LSW 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 do not apply in these circumstances.

8.12 **Return to Work**

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.

8.13 **Appeal**

At any stage when a practitioner is excluded or has restrictions place on their practice, they may appeal to a panel convened by LSW. Once an appeal has been heard, the practitioner will not be allowed to appeal again for a period of three months. The panel will consist of an Executive Director appointed by the MD to chair the panel, a consultant appointed by the Local Negotiating Committee and a third member from the same specialty and grade as the excluded practitioner from outside the organisation. The panel will recommend to the CE whether the exclusion or restriction should continue or be lifted.

9 Process for informal management

9.1 Initial meeting to act on low level performance concerns

When there is evidence that an individual is not performing to an agreed level of professional competency or there are mental or physical health issues the clinical director or clinical lead will assess the situation and may seek advice from the MD. A meeting will take place between the individual and the clinical lead or director. At this meeting the performance concerns are discussed and clarified. Where appropriate, evidence may be provided (e.g. incident forms, patient complaints etc.).

9.2 The presence and potential impact of any “distracters” i.e. factors which may adversely influence performance, must be explored and documented. The individual will have the opportunity to consider allegations regarding their performance and to raise any mitigating factors, particularly relating to team or organisational context. If organisational factors which are adversely affecting their performance are identified, the clinical lead/director should raise these with the relevant person who is able to influence these factors, and agree an organisational action plan.

9.3 During the meeting an action plan should be agreed. The action plan will include details of any additional training, mentoring or other support resources that the organisation will provide. The content should be SMART and include plans for monitoring and reviewing progress within an agreed timeframe. It should also include whether further evidence is to be gathered e.g. gaining feedback from colleagues, having practice or procedures supervised etc.

9.4 Arrangements for a subsequent meeting to review performance against the action plan should be agreed by both parties. This should be backed up with evidence and supporting statements. Where the action plan has been achieved, no further action will be taken and this will be confirmed in writing to the individual. If the action plan has not been achieved, a decision needs to be taken on whether there are mitigating reasons for this, and whether the time frames and/or actions should be amended. In this case a further review period should be agreed.

9.5 If it is felt by the clinical lead/director that the individual has failed to meet the reasonable requirements of the action plan, or indeed not taken the process seriously, the case should be raised with the MD, Locality Manager and DHHR. Failure to comply with the agreed action plan without good reason (e.g. work absence due to ill health) or the presence of continuing adverse events or behaviour will result in initiation of the serious performance concerns process (see below)

9.6 The contents of the meeting will be documented, and provided to the individual within seven calendar days of the date of the meeting, alongside a copy of the agreed action plan. A copy (including action plan) should be sent to the MD/Responsible Officer and Locality Manager for information.

10 Serious performance concerns

10.1 In severe cases of unsatisfactory performance, particularly where there are patient safety issues, lack of insight or failure of progress on previous remedial action plans the MD, Locality Manager and DHHR must be informed. LSW will consider whether it is necessary to place temporary restrictions on an individual’s practice (in line with Maintaining High Professional Standards in the Modern NHS DH 2005) Consider referral to the GMC or GDC. Consideration should be given to issuing an alert letter.

10.2 Support for individuals with ill health

10.2.1 Where there is an incident that points to a problem with the practitioner's health, the clinical lead/clinical director must immediately refer the practitioner to Occupational Health & Wellbeing. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the MD. A meeting should be convened with the DHHR, the MD or case manager, the practitioner and case worker from the Occupational Health & Wellbeing to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.

10.2.2 If a doctor or dentist's ill health makes them a danger to patients which they do not recognise, or are not prepared to co-operate with measures to protect patients, then exclusion from work (in line with Maintaining High Professional Standards in the Modern NHS DH 2005) and referral to the professional regulatory body must be considered, irrespective of whether or not they have retired on the grounds of ill health.

10.2.3 In cases where there is impairment of performance solely due to ill health, disciplinary procedures will be considered only in exceptional circumstances. This may include a practitioner who refuses to co-operate with the employer to resolve the underlying situation e.g. by repeatedly refusing a referral to Occupational Health & Wellbeing or NCAS. In these circumstances the procedures in 10.2.4 should be followed.

10.2.4 If an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated then LSW will refer the individual to Occupational Health & Wellbeing for urgent assessment. Unreasonable refusal to accept a referral to, or to co-operate with, the Occupational Health & Wellbeing under these circumstances, may give separate grounds for pursuing disciplinary action.

10.3 Reasonable adjustments

At all times the practitioner will be supported by LSW and the Occupational Health & Wellbeing service which will ensure that the practitioner is offered every available resource to get back to practice where appropriate. LSW will consider what reasonable adjustments could be made to their workplace or other arrangements, in line with the DDA. For example:

a) Making adjustments to the premises;
b) Re-allocating some of a disabled person's duties to another;
c) Transferring an employee to an existing vacancy;

d) Altering an employee's working hours or pattern of work;
e) Assigning the employee to a different workplace;
f) Allowing absence for rehabilitation, assessment or treatment;
g) Providing additional training or retraining;
h) Acquiring/modifying equipment;
i) Modifying procedures for testing or assessment;
j) Providing a reader or interpreter

10.4 In some cases retirement due to ill health may be necessary. This 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 must first be resolved, using the appropriate agreed procedures.

11 Conduct and disciplinary matters

11.1 Principles:

In cases of inappropriate conduct or professional behaviour:

a) a referral to NCAS must be made at the earliest opportunity
b) the case investigator must obtain independent professional advice
c) If the case proceeds to a hearing, the panel must include a member who is medically or dentally qualified
d) the practitioner is entitled to use LSW's Grievance Policy and if they feel their case has been wrongly classified as misconduct

11.2 Safeguarding Children

When a case involves allegations of child abuse (including non-contact abuse e.g. computer based pornography), the procedures set out in "Working Together to Safeguard Children 2010" should be followed in combination with the LSW's "Allegations Management" policy

11.3 Criminal charges and potential criminal acts

11.3.1 When an investigation reveals a potential or actual criminal act this must be reported to the Police. The organisation will work with the Police to ensure there is mutual cooperation for related investigations and that local investigations do not impede any non – related Police or NHS Fraud unit investigations.

11.3.2 In cases where criminal charges are brought against a practitioner, the organisation must consider whether the practitioner can continue in their present post or be allocated to other duties (or excluded) depending on the severity of the charges and always considering the presumption of innocence in British law.

11.3.3 When criminal charges are withdrawn or if a practitioner is acquitted following a court case, further action may still be required under this policy but this will be a matter for determination in accordance with the guiding principles established in this policy.

12 Issues of capability

12.1 Deficits in knowledge and skills may render a practitioner incapable of providing a consistently high level of patient care. This may include difficulties in team working or communication, out of date or non-standard clinical practice, rigidity in working practices, physical deterioration affecting practical skills etc.

12.2 Principles:

a) The influence of physical and mental health issues on an individual's capacity must always be considered in any capability investigation. There must be early referral for occupational health assessment.
b) The context of team dynamics with directorate and organisational factors must also be considered.
c) Referral to NCAS must be made early and engaging the help of specialty associations along with other sources of advice must also be considered.
d) There may be overlap with conduct issues and standards of professional behaviour
e) In the event of a dispute of the nature of the concerns and the appropriateness of the procedure used to manage them, the practitioner is entitled to use LSW's Grievance Policy if they feel their case has been wrongly classified.

12.3 Pre-hearing process

12.3.1 Once the report of the investigation is prepared, the case manager must give the practitioner the opportunity to study the content and provide written comment. This must be submitted to the case manager within 10 working days of receipt. This time limit may be altered in exceptional cases with the prior agreement of the case manager.

12.3.2 The case manager will, taking all sources of information in account (e.g. from NCAS) and after consultation with the DHHR, decide what further action is necessary and develop an action plan accordingly. The case manager will inform the practitioner of the decision at the earliest possible opportunity and normally within 10 days of receiving the practitioner's comments.

12.3.3 A capability panel hearing will be necessary if:

a) The practitioner refuses to be referred to NCAS

b) Advice from NCAS is that an educational/remedial action plan has little chance of success because of the severity of the performance issues.

12.4 Procedure to be followed for capability panel

12.4.1 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. It will include details of the allegations and the arrangements for the proceedings including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing, if they so choose.

12.4.2 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;

12.4.3 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. LSW 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 it will act reasonably in deciding to do so, taking into account any comments made by the practitioner;

12.4.4 Should the practitioner's ill health prevent the hearing taking place, LSW will implement its usual absence procedures and involve the Occupational Health & Wellbeing Department as necessary;

12.4.5 Witnesses who have made written statements at the inquiry stage may be required to attend the capability hearing. If the organisation or the individual contests a witness statement which is to be relied upon in the hearing, the Chairman will invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel will reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing;

12.4.6 A person accompanying a witness cannot participate in the hearing.

12.4.7 The panel will comprise three people, normally two members of the Board of LSW or other senior staff appointed by the board for the

purpose of the hearing. The panel will be chaired by an Executive Director of LSW. One member must be an independent medical or dental practitioner. The members of the panel should not have been involved with the investigation.

12.4.8 The panel will take advice from the independent medical/dental member on the appropriate level of competence expected, from the DHHR and from a senior representative of the University (for clinical academics).

12.4.9 The practitioner may raise an objection to the choice of panel member within five working days of notification. LSW will 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.

12.4.10 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.

12.4.11 The practitioner may be supported in the process by a friend, partner or spouse, colleague, trade union representative 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.

13 The capability hearing

13.1 During the hearing the panel and its advisers, the practitioner and their representative, and the case manager will be present at all times. Witnesses will be admitted only when required to provide evidence and answer any questions. The Chairman of the panel will be responsible for the proper conduct of the proceedings, introduce all persons present and announce which witnesses are available to attend.

13.2 When a witness is present, they will confirm the details of their statement and give any supplementary evidence. The party calling the witness will question the witness first, followed by the other party and then the panel.

13.3 The case manager will present the management case, including calling any witnesses first. The practitioner will then ask any questions followed by the panel. This will be followed by the practitioner presenting their case, and calling any witnesses. The case manager can ask any questions, followed by the panel.

13.4 The case manager will then be invited to make a brief closing statement, summarising the key points of the case. The practitioner will then make a brief

closing statement summarising the key points. The panel shall then retire to consider its decision.

14 Possible capability panel outcomes

14.1 The panel will have the power to make the following decisions:

- No action required
- First stage notice: setting out the improvement in clinical performance to be made within a specified time scale. This will remain on the practitioner's record for six months.
- Second stage notice: setting out the improvement in clinical performance to be made within a specified time scale. This will remain on the practitioner's record for one year.
- Termination of contract.

14.2 The decision must be confirmed in writing within seven days and should include the reason for the decision, the right of appeal and notification of any intent to make a referral to the GMC/GMD or any other external/professional body.

15 Appeal against capability panel decision

15.1 The practitioner has the right of appeal against the first and second stage warning and dismissal. The practitioner must appeal to the DHHR within 25 working days from the date of the letter confirming the outcome of the capability hearing.

15.2 The 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 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.

15.3 The appeal panel should consist of three members who have not had any previous direct involvement in the case. These are the Chairman of LSW, a medically or dentally qualified member who is not employed by LSW and an independent member (trained in legal aspects of appeals) from an approved pool, who will act as designated Chairman (or suitable deputy). The designated member cannot be involved. 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.

15.4 The appeal hearing should be heard within 25 days from the date of the appeal. The decision of the appeal panel should be confirmed in writing within five working days.

15.5 During the appeal hearing, the appeal panel and advisors, Chairman of the capability hearing, the practitioner and their representative will be present. All parties should have been provided with all documents, including witness statements, details of the previous capability hearing, together with any new evidence in advance of the appeal hearing. During the appeal hearing the practitioner will present a full statement of fact and will be subject to questioning by the capability panel chairman and then the appeal panel. The capability panel chairman will then present a full statement of fact, and can be questioned by the practitioner and the appeal panel.

15.6 After summing up by both parties, the appeal panel will make their decision in private. The decision of the appeal panel shall be made in writing and copied to the case manager within five working days of the conclusion of the hearing. The decision of the appeal panel is final and binding.

16 Terms of settlement on termination of employment

16.1 In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following principles will be used by LSW in such circumstances:

a) Settlement agreements must not be to the detriment of patient safety.
b) It is not acceptable to agree any settlement that precludes either appropriate investigations being carried out or referral to the appropriate regulatory body.
c) Payment will not normally be made when a member of staff's employment is terminated on disciplinary grounds or following the resignation of the member of staff.
d) Expenditure on termination payments must represent value for money. For example, LSW should be able to defend the settlement on the basis that it could conclude the matter at less cost than other options. A clear record must be kept, setting out the calculations, assumptions and rationale of all decisions taken, to show that LSW has taken into account all relevant factors, including legal advice. The audit trail must also show that the matter has been considered and approved by the Remuneration Committee and the Board. It must also be able to stand up to public scrutiny.
e) Offers of compensation, as an inducement to secure the voluntary resignation of an individual, must not be used as an alternative to the disciplinary process.
f) All job references must be accurate, realistic and comprehensive and under no circumstance may they be misleading.

Where a termination settlement is agreed, details may be confirmed in a formal settlement agreement. Where utilised, such an agreement will include a confidentiality clause setting out what each party may say or write about the settlement. The settlement agreement is for the protection of each party, and will relate to the terms of the agreement only and not include any clauses intended

to prevent disclosure relating to matters such as concerns about patient safety or the disclosure of other information in the public interest.

17. Handling concerns about a practitioner's health

17.1 Introduction

17.1.1 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 work place factors such as stress.

17.1.2 LSW'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 public service.

17.2 Retaining the Services of Individuals with Health Problems

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

- Sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);
- Remove the practitioner from certain duties;
- Reassign them to a different area of work;
- Arrange re-training or adjustments to their working environment, with appropriate advice from NCAS and/or deanery, under the reasonable adjustment provisions in the Equality Act 2010.

This is not an exhaustive list

17.3 Reasonable Adjustment

17.3.1 At all times the practitioner will be supported by LSW and the Occupational Health & Wellbeing Service which will ensure that the practitioner is offered every available resource to get back to practise where appropriate. LSW will consider what reasonable adjustments could be made to their workplace or other arrangements, in line with the Equality Act 2010. In particular, it will consider:

- Making adjustments to the premises;
- Re-allocating some of a disabled person's duties to another;
- Transferring an employee to an existing vacancy;
- Altering an employee's working hours or pattern of work;
- Assigning the employee to a different workplace;

- Allowing absence for rehabilitation, assessment or treatment;
- Providing additional training or retraining;
- Acquiring/modifying equipment;
- Modifying procedures for testing or assessment;
- Providing a reader or interpreter;
- Establishing mentoring arrangements.

17.3.2 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.

17.4 Handling Health Issues

17.4.1 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 & Wellbeing involvement, the nominated manager must immediately refer the practitioner to a qualified occupational physician (usually a consultant) with the Occupational Health & Wellbeing Service.

17.4.2 Taking care to observe patient and staff confidentiality NCAS should be approached to offer advice on any situation and at any point where the employer is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate. If discussions with NCAS should include a consideration of an individual's health then written permission from that practitioner should be obtained if possible.

17.4.3 The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the MD and a meeting should be convened with the DHHR, the MD or case manager the practitioner and case worker from Occupational Health & Wellbeing to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.

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

17.4.5 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 & Wellbeing or NCAS. In these circumstances the procedures in Part 4 should be followed.

17.4.6 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 LSW will refer the doctor or dentist to Occupational Health & Wellbeing for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.

18. Review

18.1 This policy will be reviewed every two years or in line with changes to legislation or best practice guidance.

19. Equality Analysis Checklist (EA) statement

19.1 The Equality Analysis Checklist carried out for this policy demonstrated that for all equality groups there were no impacts, apart from for disability where there is a positive impact due to the recognition of the requirement to make reasonable adjustments under the Equality Act 2010.

REFERENCES

NCAS the Back on Track framework for further training December 2010
NCAS Understanding performance difficulties in doctors November 2004
Templates can be found at http://www.ncas.npsa.nhs.uk/
Working Together to Safeguard Children DCSF 2010
Assuring the quality of medical appraisal for revalidation RST 2009
Information Management & Quality Assurance RST December 2011
Equality Act 2010

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Medical Director

Date: 20th June 2016

Appendix A

RESOURCES AVAILABLE FOR REMEDIATION

Resolving performance concerns

The action plan will consist of a tailored process by which the defined areas of deficient practice or behaviour will be addressed. Each action plan will be individualised and may use aspects of remediation, re-skilling or rehabilitation depending on the root cause.

Remediation

Remediation refers to the process of addressing concerns about practice (knowledge, skills and behaviour) that have been recognised through assessment, investigation review or appraisal so that the practitioner has the opportunity to return to safe practice.

Rehabilitation

Rehabilitation refers to the processes supporting the practitioner who is disadvantaged by chronic ill health or disability rehabilitation should enable them to access, maintain or return to practice safety.

Re-skilling

Re-skilling is the process of addressing gaps in knowledge, skills and/or behaviours which result from an extended period of absence (usually over six months) so that the practitioner has the opportunity to return to safe practice. This may, for example, follow suspension, exclusion, maternity, carer or other statutory leave, career break or ill health (references: The Back on Track Framework for Further Training National Patient Safety Agency and National Clinical Assessment Service).

Interventions

A wide range of interventions will be available and a tailored action plan should be developed depending on individual need. The following may be useful to consider:

1. Case based reviews
2. Simulation tests
3. Supervised practice with immediate feedback
4. Videoing consultations with reflection and discussion
5. Tutorials
6. Workshops
7. Courses (internal or external)
8. Focused reading with reflective notes
9. Language/communication skills based activities
10. Behaviour coaching
11. Close monitoring of PDP via appraisal supervision process
12. Colleague and patient multi-source feedback

13. Mentoring
14. Protected learning and development time – this will need to be underpinned by clinical supervision and also professional supervision.
15. Consideration of an out-placement for the individual

Rehabilitation after ill health

This may include features from the above list but also health monitoring, reasonable adjustments to the workplace or job plan, personal adjustments to the job plan/contract and counselling. Clinical supervision and professional supervision are also required.

Examples of evidence and resources to demonstrate progress against action plan:

1. Reflective learning logs
2. Certificates of CPD
3. Meeting notes
4. Multi-source feedback including from patients and colleagues
5. Results of audits
6. Professional development plans
7. Compliments & cards
8. Complaints
9. Operating logs
10. Morbidity and mortality data
11. Feedback from work based assessments
12. Case based reviews
13. Mini CEx
14. OSCEs
15. Video recording of consultations
16. Simulation
17. Scenarios

Out-placement

An individual may undergo remediation in a work setting other than the base organisation providing there is mutual agreement between the host organisation, the individual and the base hospital. The limitations of a remedial process out with the usual team structure must be considered. See NCAS website for example of outplacement agreement.

Appendix B

Dear

I have been asked to consider an investigation into a matter, which is alleged to relate to your conduct or competence or both. The substance of the matter is detailed in the accompanying document.

At the start of this process I would like to reassure you that the investigation and management of this issue will be dealt with transparently, sensitively and quickly. I understand that this may be a very stressful time for you, and this letter is to explain the basic process to you.

An initial investigation will occur, after which it will be decided whether there is any case to answer. If there is, we will endeavour to resolve the issue informally. If this is not possible it will involve a further formal process of investigation and management which could involve outside agencies such as NCAS. Once the decision is made you will be informed of it in writing within two weeks

Please find enclosed a summary of your rights in this situation. The relevant policy for dealing with these issues is entitled “Maintaining High Professional Standards in the modern NHS” and can be found on the intranet.

I will be arranging to meet with you soon: in the meantime please feel free to contact me if you wish to discuss the matter.

Yours sincerely

Medical Director

Appendix C

Summary of the Rights of a Practitioner under the Policy for Maintaining High Professional Standards for Medical and Dental Staff

If a practitioner is subject to action under the Policy for Maintaining High Professional Standards for Medical and Dental Staff his/her rights are:

- To be represented or accompanied from the outset, by either an accredited representative of a trade union or a defence organisation, or another employee, friend, partner or spouse. Sufficient time will be allowed for the representative or companion to offer advice and prepare the case. The companion may be legally qualified but he or she will not be acting in a legal capacity. Management will give the maximum assistance in securing representation promptly so the matter can be resolved without unnecessary delay.
- To be advised of the details of the alleged misconduct in writing prior to the interview.
- To be told of the category of the alleged misconduct.
- To be given on request a copy of any disciplinary action which is retained on employees' personal file.
- To be reminded in writing of his/her right of appeal in matters classed as serious or gross misconduct
- To be informed in writing on request the name and title of the manager who has the authority to dismiss him/her.
- Entitlement to all information relating to the allegations.

Any investigative report commissioned by the MD remains the property of LSW. Summary of the findings and recommendations may be made available to give the opportunity to modify actions / behaviours. Any documents may eventually be disclosed in the event of a dispute being referred to in a court of law.

List of suitable contacts for advice

- BMA Representative:
  Richard Griffiths
  Industrial Relations Officer
  Member Local Engagement Relations Department | Member Relations Directorate
  British Medical Association
  T: 0117 945 3124 I E: rgriffiths@bma.org.uk
  Secretary: Angie Nokes
  T: 0117 945 3132 I E: anokes@bma.org.uk

- Occupational Health & Wellbeing Dept.
  Telephone: 01752 437222 (9am to 4pm Monday to Friday)

Appendix D

Template Letter to Send to Practitioner being Immediately Excluded/Restricted from Practice

Dear

I am writing to inform you that serious concerns have been raised concerning your **[personal conduct/professional conduct/professional competence/health] these** concerns are that:

[Set out details of concerns]

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

The above concerns are very serious. They need to be investigated further. I have therefore appointed **[insert name]** to investigate these concerns. It is anticipated that **[insert name]** will complete their investigation by **[insert date of four weeks from date of letter].** They will endeavour to write to you within five days of the completion of the investigation to provide you with their report on it.

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

- Your clinical duties being carried out under the supervision of the **[Medical Director/Clinical Director].**
- A restriction of your duties pending the investigation or any formal procedure that may follow if considered necessary.
- Asking you to cease clinical duties pending completion of the investigation/any procedures flowing from it.
- An NCAS assessment
- Immediately excluding you from work for **[insert period up to a maximum of two weeks]**

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

[Set out reasons for rejecting other options]

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

[insert reasons for your choice of option]

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

Insert if Excluding from work

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

During the period of exclusion you

Either

May only attend LSW's premises for audit meetings, research purposes, study or continuing professional development. Obviously there is no limitation on you attending LSW premises to receive medical treatment or to visit friends or relatives.

Or

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

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

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

Applicable in all cases
[Insert Name] a non-executive director of LSW is designated to ensure that your case is dealt with fairly and promptly.

Applicable in Exclusion cases
You may make representations to **[insert name]** on your exclusion from work.
Please do not hesitate to contact me if you have any queries.

Yours sincerely

Case Manager