# POLICY AND PROCEDURE FOR MAINTAINING HIGH PROFESSIONAL STANDARDS
FOR MEDICAL PRACTITIONERS AT FRIMLEY PARK HOSPITAL FOUNDATION TRUST

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POLICY AND PROCEDURE FOR MAINTAINING HIGH PROFESSIONAL STANDARDS FOR MEDICAL PRACTITIONERS AT FRIMLEY PARK HOSPITAL FOUNDATION TRUST

Background

1. In December 2003, the Department of Health issued the document *High Professional Standards in the Modern NHS; a framework for the initial handling of concerns about doctors in the NHS*, under cover of HSC 2003/012.

2. The new procedure is designed to replace the current disciplinary procedures contained in circular HC(90)9, as well as the Special Professional Panels (“the three wise men”) provided for in HC(82)13 and abolishes the right of appeal to the Secretary of State held by certain practitioners under Para 190 of the Terms and Conditions of Service.

3. The Directions on Disciplinary Procedures 2005 require all NHS bodies in England to implement the framework within their local procedures by 1 June 2005. Whilst the framework is only advisory for Foundation Trusts, this policy follows the national framework and it has been agreed with the LNC.

Application of Policy

4. This Policy covers:

   (a) action to be taken when a concern about a doctor first arises (Part 1);

   (b) procedures for considering whether there need to be restrictions placed on a doctor’s practice or exclusion is considered necessary (Part 2);

   (c) guidance on conduct hearings and disciplinary procedures (Part 3);

   (d) procedures for dealing with issues of capability (Part 4); and

   (e) arrangements for handling concerns about a practitioner’s health (Part 5)

5. The Policy applies to all medical practitioners employed by the Trust (“Practitioners”), although separate arrangements may be put in place for practitioners on honorary contracts.
Protecting the Public and the Role of the NCAS

6. The duty to protect patients is paramount. At any point in the process where it is decided that the practitioner is considered to be a serious potential danger to patients, staff or the public, the practitioner must be referred to the relevant regulatory body, whether or not the case has already been referred to the National Clinical Assessment Service (“NCAS”). Consideration should also be given to whether or not an alert letter should be requested.

7. There are certain stages of this Policy at which the Trust will involve the NCAS. However, consideration to involving the NCAS will be given at any stage of the handling of a case. All referrals to the NCAS should be made, initially, by the Chief Executive, Medical Director or HR Director.

PART 1 - INITIAL ACTION WHEN A CONCERN ARISES

Introduction

8. This Policy is designed to address concerns raised in relation to practitioners, whether these concern capability, conduct or health.

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

10. Concerns about the capability of doctors in training should be considered initially as training issues and the clinical tutor and the postgraduate dean should be involved from the outset.

Initial Approach to Concerns

11. It is the responsibility of the Medical Director, Clinical Director, Clinical Tutor and other medical practitioners who have a ‘supervisory’ role to advise and guide so that deficiencies in standards of work or conduct are dealt with promptly. Before any action is taken (except in very serious matters) guidance, help and advice should always be attempted if practicable. The practitioner can expect to be told of his/her shortcomings, given guidance on how to improve and an opportunity to correct deficiencies.

12. In all cases where concerns are raised that should not properly be dealt with as part of day-to-day line management, the concerns will be brought to the attention of the Chief Executive. The Chief Executive will appoint a Case Manager to examine the concerns. The Medical Director should be appointed
as Case Manager where the practitioner involved is a Clinical Director or Consultant and informed in all other cases. In all other cases involving clinical matters a medical practitioner will be delegated to manage the case. Matters of conduct may be delegated to an Executive Director for any practitioner.

13. The Case Manager will examine the concerns and consider whether the concerns can be addressed informally. Any decision in this respect should be made after consultation with the Director of Human Resources and the Medical Director (in cases where the Medical Director is not the Case Manager). The NCAS may be consulted at this stage. The NCAS CAN provide the opportunity for local managers to discuss the problem with an impartial outsider, to look afresh at a problem, see new ways of tackling it themselves, possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than the NCAS. Where there are concerns about a practitioner in training, the postgraduate dean should be involved as soon as possible.

14. If it is decided that an informal route can be followed, this should be implemented. This can include the NCAS undertaking a formal clinical performance assessment when the doctor, the Trust and the NCAS agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps. If the NCAS is asked to undertake an assessment of the doctor’s practice, the outcome of a local investigation may be made available to inform the NCAS’s work.

**Formal Consideration of Concerns**

15. This procedure should be followed where there are “serious concerns”. Serious concerns will arise where:

(a) the practitioner’s actions may have, or have, affected patient care; or

(b) there are allegations or concerns and it is decided by the Case Manager that these cannot be resolved informally; or

(c) attempts to resolve the allegations or concerns informally have failed.

16. Where the formal route is followed, the Chief Executive will confirm the appointment of the Case Manager and will advise the Trust Board that a formal investigation is taking place. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. The Medical Director (and the Case Manager, if this is not the Medical Director)
will need to work with the Director of Human Resources in each case to decide the appropriate course of action.

17. After discussions with the CEO and Director of HR, the Case Manager will appoint a Case Investigator. The Case Investigator must be appropriately experienced or trained and the seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation. The Case Investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The case investigator:

(a) must formally involve a senior member of the medical staff where a question of clinical judgement is raised during the investigation process. Where no other suitable senior doctor is employed by the Trust, a senior doctor from another NHS body will be involved.

(b) must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but the disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered.

(c) must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene a 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.

(d) must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Director of Human Resources with the Case Manager.

18. 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.

19. 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 of:

(a) the fact of the investigation;

(b) the name of the Case Investigator; and

(c) the specific allegations or concerns that have been raised.
20. The practitioner must be given the opportunity to:

(a) see any correspondence relating to the case;

(b) see a list of the people that the Case Investigator intends to interview;
   (noting that this list may alter during the course of the investigation).

(c) put their view of events to the Case Investigator; and

(d) be accompanied in accordance with the paragraph below.

21. 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 lay representative of the British Medical Association or defence Trust; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity. The Trust must be given advanced notice if a legally qualified representative is to accompany the practitioner. The Trust may also appoint a legally-qualified individual (not acting in a legal capacity) to assist the Case Investigator and/or Case Manager at any stage in the preparation and/or presentation of the Trust’s case.

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

23. If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the Case Manager should consider whether an independent practitioner from another NHS body should be invited to assist.

24. The Case Investigator should complete the investigation within four weeks of appointment and submit their report to the Case Manager within a further five days. However, in cases where this is not possible (owing to, for example, the complexity of the allegations), the Case Investigator will complete the investigation and submit their report as soon as reasonably practicable. The report of the investigation should give the Case Manager sufficient information to make a decision as to whether:
(a) there is a case of misconduct that should be put to a conduct panel in accordance with the Trust's disciplinary policy;

(b) there are concerns about the practitioner's health that should be considered by the Trust's occupational health service;

(c) there are concerns about the practitioner's performance that should be further explored using mechanisms developed by Medical Royal Colleges, NCAS or other appropriate bodies.

(d) restrictions on practice or exclusion from work should be considered;

(e) there are serious concerns that should be referred to the GMC;

(f) there are intractable problems and the matter should be put before a capability panel; and/or

(g) no further action is needed.

Involvement of the NCAS following Local Investigation

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

26. The focus of the 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 could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk. It can also include problems that are ongoing or (depending on severity) have been encountered on at least two occasions.

27. In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or Trust governance, their further management may warrant a different local process.

28. Where the Trust is considering excluding a doctor, whether or not his or her performance is under discussion, it will consider whether the NCAS should be involved. Procedures for exclusion are covered in Part Two of this Policy. It is particularly desirable to find an alternative to exclusion because it is much
more difficult to assess a practitioner who is excluded from practice than one who is working

29. A practitioner undergoing assessment by the NCAS must cooperate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the NCAS assessment is complete (in accordance with HSC 2002/011).

30. Failure to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness on the part of the doctor to work with the Trust 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.

Confidentiality

31. Confidentiality (of patients, practitioners and staff) must be maintained at all times. No press notice should usually be issued, nor the name of the practitioner released by any party, in regard to any investigation or hearing into disciplinary matters.

32. Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose, and proportionate to the seriousness of the matter under investigation. Employees should be familiar with the guiding principles of the Data Protection Act.

PART 2 - RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

Introduction

33. This part of the Policy replaces the guidance in HSG (94)49. The phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC to suspend the practitioner from the register pending a hearing of their case or as an outcome of the fitness to practise hearing.

34. Under this Policy, the Trust must ensure that:

(a) exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;

(b) 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;
(c) all extensions of exclusion are reviewed and a brief report provided to the Chief Executive and the Board;

(d) a report is provided to the Board. The HR Director will ensure that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights (which sets out details of the right to a fair trial).

(e) that unnecessary costs are not incurred as a result of the exclusion.

**General Provisions**

35. When serious concerns are raised about a practitioner, the Trust must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor in training, the postgraduate dean should be involved as soon as possible.

36. Exclusion of clinical staff from the workplace is a temporary expedient. Under this Policy, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work ("suspension") should be reserved for only the most exceptional circumstances.

37. Exclusion will be used:

   (a) to protect the interests of patients, other staff or the Trust; and/or

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

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

38. Alternative ways to manage risks, and avoid exclusion, include:

   (a) Medical or clinical director supervision of normal contractual clinical duties;

   (b) Restricting the practitioner to certain forms of clinical duties;

   (c) Restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling; and/or
(d) Sick leave for the investigation of specific health problems.

39. 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 may be sought from the NCAS. If the nature of the problem and a workable remedy cannot be determined in this way, the Case Manager should seek to agree with the practitioner to refer the case to the NCAS, which can assess the problem in more depth and give advice on any action necessary. The 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.

40. The Trust will not exclude a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed.

41. In cases where immediate exclusion is required (see below), the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

42. The authority to exclude a member of staff is vested in Executive Directors for all medical staff and in Clinical Directors for Doctors in training and non-consultant career grade staff. Normally there should be a witness from the HR department present when a practitioner is excluded.

43. The Case Investigator will provide factual information to assist the Case Manager in reviewing the need for exclusion and making reports on progress to the Chief Executive and Director of Human Resources.

Representations

44. Written representations may be made by the practitioner to the Chief Executive in regard to exclusion or investigation of a case. The Director of HR will meet with the practitioner to discuss the representations, and will then inform the practitioner of his/her decision in writing within five working days of the meeting.

45. If the practitioner is not satisfied with the Director of HR response, the practitioner can lodge a written appeal within five working days of receiving the written decision of the HR Director, giving details of the grounds for appeal.

46. A Non-Executive Director will meet with the practitioner to discuss the appeal and will inform the practitioner of his/her decision in writing within five working days of the meeting. There will be no further right of appeal.
47. The practitioner shall have no recourse to the Trust’s Grievance Procedure or other policies/procedures in relation to concerns about action taken under this Policy and all such concerns shall be raised in accordance with the process set out above.

48. The practitioner has the right to be accompanied at any meeting in relation to representations made under this Policy.

**Immediate Exclusion**

49. An immediate time limited exclusion may be necessary:

   (a) following a critical incident when serious allegations have been made; or

   (b) where there has been a break down in relationships between a colleague and the rest of the team; or

   (c) where the presence of the practitioner is likely to hinder the investigation.

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

51. The Executive Director or Clinical Director 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.

**Formal exclusion**

52. A formal exclusion (e.g. up to 4 weeks) should only take place after the Case Manager has first considered whether there is, on the face of the allegations, a case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. The NCAS may 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.

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

   (a) the allegation appears unfounded; or
(b) there is a misconduct issue; or

(c) there is a concern about the practitioner's capability; or

(d) 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.

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

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

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

or where

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

55. 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.

56. When the practitioner is informed of the exclusion, there should, where practical, be a witness present from the HR department and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner has the right to be accompanied at any formal exclusion meeting but meetings will not be delayed unreasonably due to the availability of a representative of the practitioner.

57. The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state:
(a) the effective date, time and duration of the exclusion (up to four weeks);

(b) the content of the allegations;

(c) the terms of the exclusion (including details of whether it is exclusion from work or from the premises and the need to remain available for work);

(d) the action that will follow (for example, is it a full investigation or will other action follow?); and

(e) that the practitioner and their companion may make representations about the exclusion to the Director of HR at any time after receipt of the letter confirming the exclusion.

58. 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 should still only last for four weeks at a time and be subject to review. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

59. 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 may be referred to the NCAS for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period the principle of four-week "renewability" must be adhered to.

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

Exclusion from premises

61. 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 potential danger to patients or other staff. Practitioners excluded from the premises should not harass staff for any reason. Practitioners who persist in harassing staff will face
disciplinary action. In other circumstances, however, there may be no reason to exclude the practitioner from the premises. The practitioner may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

**Keeping in contact and availability for work**

62. As exclusion should usually be on full pay, the practitioner must remain available for work with the Trust during their normal contracted hours, including on-call rota. The practitioner must inform the case manager of any other Trust(s) with whom they undertake either voluntary or paid work and seek their Case Manager’s consent to continuing to undertake such work or to take annual leave or study leave. The practitioner should be reminded of these contractual obligations but would normally 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 (for example, the practitioner is on leave without agreement).

63. The excluded practitioner will advise the Case Manager if he/she needs arrangements to be made to keep in contact with colleagues on professional developments, and take part in Continuing Professional Development (CPD) and clinical audit activities. A mentor or link colleague could be appointed for this purpose if a colleague is willing to undertake this role.

**Informing other Trusts**

64. In cases where there is concern that the practitioner may be a danger to patients, the Trust has an obligation to inform such other Trusts 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 the Trust has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice.

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

66. No practitioner should be excluded from work other than through this Policy. Informal exclusions, such as so-called ‘garden leave’, may not be used as a means of resolving a problem covered by this Policy.

**Keeping Exclusions Under Review**

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

(a) 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; and

(b) receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended.

**Regular review**

68. The Case Manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive and the Board. 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. 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.

69. The Case Manager’s report to the Board is advisory and it is for the Case Manager (rather than the Board) 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.

70. The Trust must take review action before the end of each four-week period. After three exclusions, the NCAS may be called in. The various activities that must be undertaken at different stages of exclusion are detailed below.
First and second reviews (and reviews after the third review)

71. Before the end of each period of exclusion (of up to four weeks) the Case Manager reviews the position and the following actions should be taken:

(a) The Case Manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time.

(b) The Case Manager submits advisory report of outcome to Chief Executive and the Board.

(c) Each renewal is a formal matter and must be documented as such.

(d) The practitioner must be sent written notification on each occasion.

72. If the practitioner has been excluded for three periods, the following actions must also be taken at the third review:

(a) A report must be made to the Chief Executive outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative. If the investigation has not been completed, a timetable for completion of the investigation must also be given.

(b) The Trust will consider formally referring the case to the NCAS, explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion at the earliest opportunity.

(c) The NCAS may be invited to review the case with the Trust and to advise and advise the Trust on the handling of the case until it is concluded.

Six-month Review

73. Normally there should be a maximum limit of six months’ exclusion, except for those cases involving criminal investigations of the practitioner concerned. The Trust will actively review those cases at least every six months.

The role of the Board

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

75. The Board may decide to designate one of the Non-Executive Directors to keep a watching brief on the case. If appointed, the NED will ensure that
continuing exclusion is justified and will advise the Board whether they believe the case is proceeding at an appropriate pace.

Return to Work

76. 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.

PART THREE - CONDUCT HEARINGS AND DISCIPLINARY MATTERS

Introduction

77. Misconduct matters for doctors, as for all other staff groups, must be resolved within the Trust. All issues regarding the misconduct of doctors will be dealt with in accordance with the Trust’s Disciplinary Procedure covering other staff charged with similar matters. Nevertheless, the Trust may seek advice from the NCAS.

78. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the Case Investigator may need to obtain appropriate professional advice.

79. Similarly, where a case involving issues of professional conduct proceeds to a hearing under the Trust’s disciplinary procedures the panel will include a member who is medically qualified and who is not currently employed by the Trust. This member should normally be currently employed by another NHS organisation.

80. It is for the Trust to decide upon the most appropriate way forward. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to make representations to the CEO. Any such representations will be considered in accordance with paragraphs 43-47 above.

Allegations of Criminal Acts

81. Where the investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust will consult the police to establish whether the Trust’s own investigation can continue or whether this would impede the police investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.
**Cases where criminal charges are brought not connected with an investigation by the Trust**

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

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

**PART FOUR - PROCEDURE FOR DEALING WITH ISSUES OF CAPABILITY**

**Introduction**

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

(a) out of date clinical practice;

(b) inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;

(c) incompetent clinical practice;

(d) inability to communicate effectively;

(e) inappropriate delegation of clinical responsibility;

(f) inadequate supervision of delegated clinical tasks;

(g) ineffective clinical team working skills.

86. Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. The NCAS can provide expert advice and support for local action to support the remediation of a doctor and should normally be consulted.

87. Any concerns about capability relating to a doctor in recognised training grades will be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor, with close involvement of the postgraduate dean from the outset.

88. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the Trust to decide on the most appropriate way forward. The procedures set out below are designed to cover issues where a doctor’s capability to practice is in question. Prior to instigating these procedures, the Trust will consider the scope for resolving the issue through counselling or retraining and will take advice from the NCAS as appropriate.

89. Capability may be affected by ill health. Arrangements for handling concerns about a practitioner’s health are described in Part Five of this Policy.

90. The Trust will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds. Those undertaking investigations or
sitting on capability or appeals panels must have had formal equal opportunities training before undertaking such duties.

The Pre-Hearing Process

91. When a report of the investigation has been received, the Case Manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

92. The Case Manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and any advice received from the NCAS. The Case Manager will need to consider urgently whether action under Part Two of the framework is necessary in order to exclude the practitioner, or whether to place temporary restrictions on their clinical duties.

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

94. The NCAS will assist the Trust to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust will facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by the NCAS, but the advice of its assessment panel is that the practitioner’s performance is so fundamentally flawed that no educational and/or Trust action plan has a realistic chance of success. In these circumstances, the Case Manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

95. If the practitioner does not agree to the case being referred to the NCAS, a panel hearing will normally be necessary.
96. The following procedure should be followed before the hearing:

(a) The Case Manager must notify the practitioner in writing of the decision to arrange a capability hearing. This notification should be made at least 20 working days before the hearing and include details of the allegations and the arrangements for proceeding including the practitioner’s rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so choose.

(b) 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 Case Manager will ask the Chairman of the panel whether the evidence can be admitted or whether to adjourn the panel.

(c) Should either party request a postponement to the hearing the Case Manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not normally less than 30 working days), to proceed with the hearing in the practitioner’s absence.

(d) Should the practitioner’s ill health prevent the hearing taking place, the Trust will implement its usual absence procedures and involve the Occupational Health Department as necessary. The OH Physician will advise when the practitioner will be fit to attend a hearing. A failure to comply with the Trusts absence procedures may lead to disciplinary action.

(e) Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.

(f) If witnesses required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.
The Capability Hearing

97. The capability hearing will normally be chaired by an Executive Director of the Trust. The panel should comprise a total of three people, normally two members of the Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be a medical practitioner who is not employed by the Trust. The practitioner should normally be currently employed by another NHS employer.

98. As far as is reasonably possible or practical, no member of the panel or advisers to the panel should have been previously directly involved in the investigation.

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

   (a) A senior member of staff from Human Resources, and

   (b) A senior clinician from the same or similar clinical specialty as the practitioner concerned, but from another NHS employer.

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

101. It is for the Trust to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust should review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner.

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

103. The practitioner may be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence Trust. Such a representative may be legally qualified but they will not, however, 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. Similarly, the Trust may also appoint a legally-qualified individual (not acting in a legal capacity) to assist the Case Investigator and/or Case Manager at any stage in the preparation and/or presentation of the Trust’s case. The Trust’s representative will be entitled to present the case
on behalf of the Trust, address the panel and question the practitioner’s case and any witness evidence.

104. The hearing should be conducted as follows:

(a) The panel and its advisers, the practitioner, his or her representative and the Case Manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire.

(b) The Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing.

(c) The procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:

   - The witness to confirm any written statement and give any supplementary evidence.
   - The side calling the witness can question the witness.
   - The other side can then question the witness.
   - The panel may question the witness.
   - The side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.

105. The order of presentation shall be as follows:

(a) The Case Manager presents the management case including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.

(b) The Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.

(c) The practitioner and/or their representative shall present the practitioner’s case, calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.
(d) The Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification.

(e) The Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case.

(f) The Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner’s case. Where appropriate this statement may also introduce any grounds for mitigation.

(g) The panel shall then retire to consider its decision.

**Decisions**

106. The panel will have the power to make a range of decisions. The decision reached should take account of the severity of the matter and likelihood of the performance improving to an acceptable standard within the duration of the warning.

(a) No action required.

(b) Oral agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required from all parties and how it might be achieved. *Such an agreement does not constitute disciplinary action.*

(c) Written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved (which stays active on the employee’s record for 1 year).

(d) Final written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved (which stays active on the employee’s record for 18 months).

(e) Termination of contract (with notice).

107. It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the Trust that the panel wishes to comment upon.
108. A record of oral agreements and written warnings should be kept on the practitioner’s personnel file but should be inactive following the specified period.

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

110. The decision must be confirmed in writing to the practitioner. This notification must include reasons for the decision, clarification of the practitioner’s right of appeal and notification of any intent to make a referral to the GMC or any other external/professional body.

111. Prior to a warning becoming inactive or ‘spent’ the Case Manager, with the practitioner’s line manager, will formally review the practitioner’s clinical performance. The process of review will be agreed with the practitioner when the warning is issued. If performance is judged satisfactory the warning will lapse. If there has been insufficient improvement the warning may be extended for a further period, not exceeding six months. Alternatively the capability panel may be reconvened (as far as possible using the same panel members as previously). The range of decisions open to the reconvened panel is as set out in para 106 above (including the option of termination of contract).

**Appeal Process**

112. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust’s procedures have been adhered to and that the panel in arriving at their decision acted fairly and reasonably based on:

(a) A fair and thorough investigation of the issue;

(b) Sufficient evidence arising from the investigation or assessment on which to base the decision;

(c) Whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

113. The appeal panel can also hear new evidence submitted by the practitioner providing that there is good reason as to why this was not available to the original panel. The panel can consider whether it might have
significantly altered the decision of the original hearing. The appeal panel, however, will not rehear the entire case.

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

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

116. The appeal panel should consist of three members. The members of appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal. These members will be:

(a) An independent member (trained in legal aspects of appeals). This person is designated Chairman.

(b) The Chairman or other non-executive director of the Trust who must have the appropriate training for hearing an appeal.

(c) A medically qualified member who is not employed by the Trust and who must also have the appropriate training for hearing an appeal.

117. The panel should call on others to provide specialist advice. This should normally include a Consultant from the same specialty or subspecialty as the appellant. A Senior Human Resources specialist should also be appointed.

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

119. The Trust will arrange the panel and notify the appellant as soon as possible and in any event within the recommended timetable set out below. Every effort should be made to ensure that the panel members are
acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant’s objections should be noted carefully.

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

(a) Appeal by written statement to be submitted to the Director of Human Resources within 25 working days of the date of the written confirmation of the original decision.

(b) Hearing to take place within 25 working days of date of lodging appeal.

(c) Decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

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

122. 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 written reasons for calling the witness together with the general areas of questioning. If possible, a written statement from any such witness will be given to the parties ahead of the hearing.

123. Exceptionally, where during the course of the hearing the appeal panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

124. If, during the course of the hearing, the appeal panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance. The appeal panel has the power to determine whether to consider the new evidence as relevant to the appeal, or whether the case should be reheard, on the basis of the new evidence, by a capability hearing panel.

125. At the hearing, all parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence. The practitioner may be represented in the process by a friend, partner or spouse, colleague or a representative who may be from or retained by a trade union or defence Trust. Such a representative may be legally
qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence. Similarly, the Trust may also appoint a legally-qualified individual (not acting in a legal capacity) to assist the Case Investigator and/or Case Manager at any stage in the preparation and/or presentation of the Trust’s case. The Trust’s representative will be entitled to present the case on behalf of the Trust, address the panel and question the practitioner’s case and any witness evidence.

126. Both parties will present full statements of fact to the appeal panel and will be subject to questioning by either party, as well as the panel. When all the evidence has been presented, both parties shall briefly sum up. At this stage, no new information can be introduced. The appellant (or his/her companion) can at this stage make a statement in mitigation.

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

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

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

**Termination of employment with performance issue unresolved**

130. Where the employee leaves employment before disciplinary procedures have been completed, the investigation must be taken to a final conclusion in all cases and capability proceedings must be completed wherever possible, whatever the personal circumstances of the employee concerned.

131. Every reasonable effort must be made to ensure the employee remains involved in the process. If contact with the employee has been lost, the Trust will invite them to attend any hearing by writing to both their last known home
address and their registered address (the two will often be the same). The Trust must make a judgement, based on the evidence available, as to whether the allegations about the practitioner’s capability are upheld. If the allegations are upheld, the Trust must take appropriate action, such as requesting the issue of an alert letter and referral to the professional regulatory body, referral to the police, or the Protection of Children Act List (held by the Department for Education and Skills).

132. If an excluded employee or an employee facing capability proceedings becomes ill, they should be subject to the Trust’s usual sickness absence procedures. The sickness absence procedures take precedence over the capability procedures and the Trust should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 3 weeks, they must be referred to the Occupational Health Service. The Occupational Health Service will advise the Trust on the expected duration of the illness, whether the practitioner is fit to attend the hearing and any consequences it may have for the capability process and will also be able to advise on the employee’s capacity for future work, as a result of which the Trust may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the Trust form a judgement as to whether the allegations are upheld.

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


PART FIVE – HANDLING CONCERNS ABOUT A PRACTITIONER’S HEALTH

Introduction

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

136. The principle for dealing with individuals with health problems is that, wherever reasonably possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS. Wherever reasonably possible the Trust
should attempt to continue to employ the individual provided this does not place patients or colleagues at risk.

**Dealing with Ill Health**

137. The following are examples of action that the Trust may take to address ill health issues:

(a) sick leave for the practitioner (the practitioner to be contacted frequently on a pastoral basis to stop them feeling isolated);

(b) remove the practitioner from certain duties;

(c) reassign them to a different area of work;

(d) arrange re-training or adjustments to their working environment, with appropriate advice from the NCAS and/or deanery, in accordance with the reasonable adjustment provisions in the Disability Discrimination Act 1995.

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

139. The following are examples of reasonable adjustments that may be considered by the Trust:

(a) Make adjustments to the premises
(b) Re-allocate some of the disabled person’s duties to another
(c) Transfer employee to an existing vacancy
(d) Alter employee’s working hours or pattern of work
(e) Assign employee to a different workplace
(f) Allow absence for rehabilitation, assessment or treatment
(g) Provide additional training or retraining
(h) Acquire/modify equipment
(i) Modifying procedures for testing or assessment
(j) Provide a reader or interpreter
(k) Establish mentoring arrangements

140. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures where appropriate.
141. 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 involvement, the nominated manager must immediately refer the practitioner to a qualified occupational physician with the Occupational Health Service.

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

143. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of Human Resources, the Medical Director or Case Manager, the practitioner and case worker from Occupational Health to agree a timetable of action and rehabilitation (where appropriate).

144. 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.

145. Confidentiality must be maintained by all parties at all times.

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

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

148. There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the doctor to Occupational Health for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, Occupational Health under these circumstances, may give separate grounds for pursuing disciplinary action.
149. Special Professional Panels (generally referred to as the “three wise men”) were set up by District Health Authorities under circular HC (82)13. This part of the Policy replaces HC (82)13 which is cancelled and any existing panels should be disbanded.