Sheffield Health and Social Care
NHS Foundation Trust

Policy:

MD001 Disciplinary, Capability, Ill health and Appeals for Medical Practitioners

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This policy was originally issued in June 2007. It has been updated in November 2012 to include a specific addendum on remediation. In June 2018 it was amended to include within its scope salaried General Practitioners employed by the Trust and to update the need for references to external bodies. The Policy was further revised in September 2021 to ensure its content was consistent with national policy and MHPS.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
1.0	New policy implemented	06/2007	New policy.
2.0	Addition of content	11/2012	Specific addendum on remediation
3.0	Scope increased to cover GPs	06/2018	Include salaried General Practitioners employed by the Trust and to update the need for references to external bodies..
4.0	Rewrite	09/2021	Amended to reflect current national policy and procedure

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INTRODUCTION

This is an agreement between Sheffield Health & Social Care Trust ("the Trust") and the Local Negotiating Committee ("the LNC") outlining the employer's procedure for handling concerns about medical practitioners" conduct and capability (including ill health capability). It implements the framework set out in "Maintaining High Professional Standards in the Modern NHS", issued under the direction of the Secretary of State for Health on 11 February 2005. This procedure replaces the previous 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.

This policy should be used for managing issues of capability (performance and ill health) and conduct involving medical practitioners. However, it should be noted that medical practitioners are required to comply with all other Trust HR policies and guidance, including the statement on resolving differences of opinion between practitioners.

This procedure may be amended to reflect any future national advice or guidance but only by agreement within the JLNC. Where there is any conflict or lack of clarity the existing national agreed guidance will take precedence.

The Trust will ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of protected characteristics as set out in the Trust's Equal Opportunities and Diversity Policy.

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

MHPS document predates the introduction of Medical Revalidation and the creation of the Responsible Officer role. In SHSC, the Responsible Officer role has been performed by a senior doctor who is not the Medical Director. This policy takes account of the respective responsibilities of the Medical Director and the Responsible Officer in relation to dealing with concerns about medical staff.

An Addendum has been introduced to this policy to ensure that proper account is taken of the use of remediation in appropriate circumstances. It is envisaged that remediation will generally be a matter of agreement with the relevant clinical line manager in terms of the areas for the development of the practitioner. Such discussions and agreement may take place, for example, during clinical supervision and/or appraisal. In such circumstances, the provisions of this policy would not need to be applied beyond potentially an initial informal investigation by the clinical manager. However, there may be occasions where there is no agreement on the requirement for and /or the nature of the development/improvement which is believed to be appropriate. In such cases, a Case Manager may need to be appointed 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 proceedings (see section 1.12). Depending on the outcome of that consideration, further application of this policy (including remediation interventions, as appropriate) would be instigated.

There may also be occasions where the seriousness of the problem or concern raised requires the application of this policy from the outset (including remediation interventions, as appropriate).

The GMC had commissioned independent research into the reasons for over-representation of certain groups of doctors within the number of doctors who are referred to GMC. The results were published in 2019 in a report titled 'Fair to Refer?' In 2021, GMC published its target for tackling this overrepresentation by 2026. The Trust is committed to working with the GMC to achieve that target.

This Policy also applies to salaried General Practitioners who are employed by the Trust whether by virtue of a transfer (under the legislation governing a transfer of undertaking) or otherwise. A second Addendum has been added to this document to set out the additional liaison which may be required with NHS England (or any relevant successor body) when operating the procedures for this group of staff.

1 ACTION WHEN A CONCERN ARISES –

Introduction

1.1 The management of standards of performance, conduct and attendance is a continuous cycle which commenced at the point of employment and continues through the employment life cycle. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or service users harmed; and which need not necessarily require formal investigation or resort to disciplinary procedures.

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

1.2 Unfounded and malicious allegations can cause lasting damage to a medical practitioner's reputation and career prospects. Therefore, all allegations, including those made by relatives of service users, 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.

1.3 The Trust encourages an informal, team-based approach to resolving conflict and differences of opinion relating to care of service users. The guidance entitled “Resolving Differences of Opinion Between Practitioners” dated 8 September 2006 restates this. This will be further developed as part of the implementation of the GMC Fair to Refer recommendations where the Trust aims to introduce a mechanism whereby, before a formal complaint process is initiated, someone who is impartial to the issues involved and understands diversity, evaluates whether a formal response is necessary.

1.4 Concerns about the capability of medical practitioners in training should be considered initially as training issues and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset. The Postgraduate Dean should be contacted to discuss and agree the correct process for dealing with the doctor concerned. It may be appropriate to inform the Postgraduate Dean where concerns arise around the conduct of medical practitioners in training, depending on the circumstances. If the Trust feels this is appropriate the Postgraduate Dean should be contacted to discuss and agree the correct process for dealing with the medical practitioner concerned.

1.5 Where Practitioners are not employed by the Trust but are working in the Trust, their employer (normally Trust, or University for honorary contract holders) should be contacted to agree appropriate action. The Trust will seek to agree joint procedures for dealing with such cases. Where the Trust employs medical practitioners and they are working in another organisation (NHS or otherwise) when a concern arises, the Trust will contact the other organisation to discuss and agree the correct process for dealing with the medical practitioner concerned.

1.6 Where medical practitioners undertake roles such as Educational Supervisor, Programme Director, Associate Postgraduate Dean and a concern is raised about the medical practitioners in connection with him or her undertaking that role, the Trust will consult with the Postgraduate Dean regarding appropriate action.

1.7 All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. A serious concern which relates to the clinical conduct of a medical practitioner will be dealt with under the terms of this policy.

1.8 All concerns should firstly be investigated on an informal basis via a fact finding process. Thereafter any formal investigations must be investigated quickly using the appropriate policy.

1.9 The Chair of the Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. A clear audit route must be established for initiating and tracking progress of the investigation and resulting action. (See appendix C).

1.10 The Medical Director will need to work with the People Director to decide the appropriate course of action in each case. The Medical Director will act as the case manager in cases involving clinical managers of clinical director level or above and consultants, and may delegate this role to an appropriate manager to oversee the case on their behalf for other grades of medical practitioners. The Medical Director is responsible for appointing a case investigator.

Identifying if there is a problem

1.11. 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. They will also consider whether it can be resolved without resort to formal procedures. This is a difficult decision and should not be taken alone but in consultation with the People Director, the Medical Director (if he or she is not already the case manager) and Practitioner Performance Advice Service - PPA (formerly NCAS). The Responsible Officer will be made aware of the concerns.

1.12. The case manager should explore the root cause of the problem with the PPA. 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 Service Patient Safety Agency ("NPSA") facilitates the development of an open and fair culture, which encourages medical practitioners 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.

1.13. Having discussed the case with the PPA and/or NPSA, the case manager must decide whether an informal approach can be used to address the problem and under which Trust Policy, or whether a formal investigation will be necessary. Where an informal route is chosen, PPA should still be involved until the problem is resolved.

1.14. Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and People Director, appoint an appropriately experienced or trained person as case investigator. This could be an external practitioner if appropriate. 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.

1.15. The case investigator:

- Will be appointed by the Medical Director
- Is responsible for leading the investigation into any allegations or concerns about a medical practitioner, establishing the facts and reporting the findings;
- Must formally involve a medical practitioner nominated by the medical staff committee chair where a question of clinical judgment is raised during the investigation process.
- Must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Service user 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 and should seek advice from the Caldicott Guardian and the Trust Information Manager, in accordance with the relevant data protection legislation.
- Must ensure that there are sufficient written statements and any other relevant documentation and evidence 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 recorded and given sufficient weight in the investigation report.
- Must ensure that a written report is kept of the investigation, the conclusions reached and the course of action agreed by the People Director with the Medical Director (if not the case manager).
- Must assist the designated Board member in reviewing the progress of the case, including the need for ongoing exclusion or restriction of practice, see relevant section below.

The investigation

1.16. 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.

1.17. 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 be made aware of the specific allegations arising from the concerns that have been raised. The medical practitioner must be given the opportunity to see any documentation relating to the case together with a list of the people that the case investigator will interview. The medical practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied.

1.18. At any stage of this process, or subsequent disciplinary action, the medical practitioner may be accompanied in any interview or hearing by another employee of the Trust ; an official or representative of the British Medical Association or any other recognised trade union of which the practitioner is a member; a representative of a defence organisation – not acting in a legal capacity.

1.19. The case investigator has discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended simply to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter. The case investigator should not make recommendations to the case manager in his or her report as to how the case should be handled but should detail conclusions at the end of the report drawing together the key findings.

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

- There is a case of misconduct that should be put to a Disciplinary panel;
- There are concerns about the practitioner's health that should be manged using the Trusts Policy on Promoting Attendance at Work;
- There are concerns about the practitioner's performance that should be further explored by the PPA;
- Restrictions on practice or exclusion from work should be considered;
- There are serious concerns that should be referred to the GMC. Any referral to GMC should be made by the Trust's RO, after discussion with the Medical Director/Case Manager and GMC ELA.
- There are problems relating to competence, and the matter should be put before a capability panel;
- No further action is needed.

In complex cases, it may be appropriate for an external Medical Practitioner to be involved as deemed necessary by the Medical Director.

Other formal action may be agreed between the Case Manager and the individual concerned.

Involvement of the PPA following local investigation

1.21. Performance and conduct falling short of required standards 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. PPA processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. PPA methods of working therefore assume commitment by all parties to take part constructively in a referral to the PPA. For example, its assessors work to formal terms of reference, decided on after input from the medical practitioner and the referring body.

1.22. The focus of PPA's work is likely to be around performance difficulties which are serious and/or repetitive. That means:

- Performance falling well short of what medical practitioner could be expected to do in similar circumstances and which, if repeated, would put service users 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 service user complaints or organisational governance, their further management may warrant a different local procedure (which may involve referral to the NHS counter fraud service). PPA may advise on this.

1.23 Where the Trust is considering excluding a medical practitioner (whether or not his or her performance is under discussion with the PPA), the Trust will inform PPA of this at an early stage, so that alternatives to exclusion are considered. Procedures for exclusion are covered in section 2 of the procedure. It is particularly desirable to find an alternative when PPA is likely to be involved, because it is much more difficult to assess a medical practitioner who is excluded from practice than one who is working.

1.24 A practitioner undergoing assessment by the PPA must cooperate with any request to give an undertaking not to practice in the NHS or private sector other than their main place of NHS employment until the PPA assessment is complete. (Under circular HSC 2002/011, Annex 1, paragraph 3, "A medical practitioner undergoing assessment by the PPA must give a binding undertaking not to practice in the NHS or private sector other than in their main place of NHS employment until the assessment process is complete”).

1.25 Failure to co-operate with a referral to the PPA may be seen as evidence of a lack of willingness on the part of the medical practitioner to work with the employer on resolving performance difficulties. If the medical 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

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

1.27. 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. The Trust will operate consistently with the guiding principles of the relevant data protection legislation. Advice on this may be sought from the Caldicott Guardian for the Trust and the Trust Information Manager.

2. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

Introduction

2.1. This part of the procedure replaces the guidance in HSG (94)49 and the Trust’s Disciplinary Policy in relation to issues of personal conduct and suspension.

2.2. 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 a fitness to practice hearing.

2.3. When serious concerns are raised about a practitioner, the Trust will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings, or provide for the exclusion of the practitioner from the workplace. Section 2 of this document sets out the procedures for this action.

2.4. At any point in the process where the Case Manager has reached the clear judgment that a practitioner is a serious potential danger to service users or staff, that practitioner must be referred to the GMC, whether or not the case has been referred to the PPA. The GMC expects that it is the Trust’s Responsible Office (RO) who makes this referral, after discussion with the Medical Director/Case Manager and the GMC‟s Liaison Adviser (ELA). Consideration should also be given to whether the issue of an alert letter should be requested, and whether safeguarding teams should be involved.

2.5. The Trust will ensure that:

- Exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
- Where a medical practitioner is excluded, it is for the minimum necessary period of time: this can be up to but no more than four weeks at a time;
- All extensions of exclusion are reviewed and a brief report provided to the Chief Executive and the Board;
- A detailed report is provided when requested to the Designated Board Member, who will be responsible for monitoring the situation until the exclusion has been lifted.

Managing the risk to service users

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

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

2.8. Exclusion will only be used:

- To protect the interests of service users or other staff; and/or
- To assist the investigative process when there is a clear risk that the medical 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 of the concerns and on the need to protect service users, the practitioner concerned and/or their colleagues.

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

- Medical or clinical manager 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;

  For the investigation of specific health problems, the Trust's Promoting Attendance and Managing Sickness Absence Policy needs to be adhered to.

The practitioner should co-operate with the Trust in finding alternatives to exclusion and should confirm in writing, if asked, any agreement to such alternatives in order to ensure there is no confusion about them. If they are unclear as to what is required, then they should seek immediate clarification from the Case Manager. A refusal to give any such commitment if asked is a factor the Case Manager can legitimately take into account when deciding whether to exclude or not.

2.10. In cases relating to the capability of a medical practitioner, consideration will be given to whether an action plan to resolve the problem can be agreed with the medical practitioner. Advice on the practicality of this approach will be sought from PPA. 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 medical practitioner to refer the case to PPA, which can assess the problem in more depth and give advice on any action necessary. The case manager will seek immediate telephone advice from PPA when considering restriction of practice or exclusion.

The Exclusion / Restriction Process

2.11. The Trust will not exclude or place restrictions on a medical practitioner for more than four weeks at a time. The justification for continued exclusion or restriction must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Key officers and the Trust Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion or restriction is not prolonged. It is important that the practitioner receives appropriate support when they return to work.

Roles of officers

2.12. The Trust's Chief Executive has overall responsibility for managing exclusion and restriction procedures and for ensuring that cases are properly managed. The decision to exclude or restrict a practitioner must be taken only by persons nominated under paragraph 2.11. The case will be discussed fully with the Chief Executive, the Medical Director, the Human Resources Director or their nominated representative as appropriate. PPA and other interested relevant parties (such as the police where there are serious criminal allegations, the Local Counter Fraud & Security Management Service and Crown Prosecution Service) prior to the decision to exclude or restrict the activities of a practitioner. In the rare cases where immediate exclusion or restriction is required, the above parties must discuss the case at the earliest opportunity following exclusion or restriction, preferably at a case conference.

2.13. The authority to exclude a member of medical practitioner is vested in the Chief Executive (or nominated deputy) and Medical Director (or nominated deputy). Clinical Managers (who are medical practitioners) or the HR Director, where the appropriate clinical manager is unavailable, are authorised to exclude members of medical practitioners for grades below consultant level only.

2.14. The Medical Director will act as the case manager in the case of consultant staff, or can delegate this role to an appropriate manager to oversee the case for other staff, and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude or restrict the staff member. The case investigator (as referred to in paragraph 1.16) will provide factual information to assist the case manager in reviewing the need for exclusion and restriction and making progress reports to the Chief Executive and designated Board member.

Role of designated Board member

2.15. At any stage in the process, the medical practitioner may make representations to the designated Board member in regard to exclusion, restriction of practice, or investigation of a case. This is in addition to any right the practitioner may have to appeal against the exclusion or restriction under the Trust's appeal process in paragraph 2.40.
The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights. This information may be obtained through the Trust's solicitors via Human Resources.

Immediate exclusion

2.16. In exceptional circumstances, an immediate time-limited exclusion may be necessary for the purposes identified in paragraph 2.6 above following, for example:

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

Such an exclusion will allow a more measured consideration to be undertaken and PPA should be contacted before the immediate exclusion takes place. This period should be used to carry out a preliminary situation analysis, to seek further advice from PPA 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 medical practitioner should return to the workplace for a further meeting.
The case manager must advise the medical practitioner of their rights, including rights of representation.

Formal exclusion / restriction

2.17. A formal exclusion or restriction on practice 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 or restrict practice. PPA 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 (needs to be linked in to the duties of the case investigator referred to in paragraph 1.16, penultimate paragraph. This preliminary report is advisory to enable the case manager to decide on the next steps as appropriate.

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

- The allegation appears unfounded; or
- There is a potential misconduct issue; or
- There is a concern about the medical practitioner's capability; or
- The complexity of the case warrants further detailed investigation before advice can be given on the way forward and what needs to be inquired into.

2.19. Formal exclusion of must only be used where:

(a) There is a need to protect the interests of service users 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, or
-

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

2.20. Full consideration should be given to whether the medical 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.

2.21. When the medical practitioner is informed of the exclusion or restriction on practice, there should be a witness present and the nature of the allegations or areas of concern should be conveyed to the medical practitioner. The medical practitioner should be told of the reason(s) why formal exclusion or restriction on practice is regarded as the only way to deal with the case. At this stage the medical 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 PPA with voluntary restriction), or restriction on practice.

2.22. The formal exclusion or restriction on practice must be confirmed in writing as soon as is reasonably practicable. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion or restriction on practice as referred in paragraph 2.23 and 2.24 below. The medical practitioner and their companion should be advised that they may make representations about the exclusion or restriction on practice to the designated board member at any time after receipt of the letter confirming the exclusion or restriction on practice.

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

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

2.25. If at any time after the medical practitioner has been excluded from work or has had his her practice restricted, investigation reveals that either the allegations are without foundation or that further investigation can continue with the medical practitioner working normally or with restrictions, the case manager must lift the exclusion or restriction on practice, and inform any relevant external body who had been previously notified by the Trust of the exclusion or restriction and keep them updated until the matter is resolved.

Exclusion from premises

2.26. Medical practitioners will not be automatically barred from the premises upon exclusion from work or on restriction on practice. The case manager must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the medical 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 medical practitioner may be a serious potential danger to service users or other staff. In other circumstances, however, there may be no reason to bar the medical practitioner from the premises. As an alternative to complete exclusion from Trust property, the Case Manager may consider a limited exclusion from certain parts of Trust property. In the event that such an exclusion is put in place but then breached by the practitioner, a full exclusion can be substituted. The practitioner should always be allowed on appropriate Trust property as a patient.

Keeping in contact and availability for work

2.27. The medical practitioner should be allowed 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.

2.28. Exclusion or restriction on practice under this procedure will be on full normal pay, therefore the medical practitioner must remain available for work with their employer during their normal contracted hours including any on-call periods. The medical practitioner must inform the case manager of any other organisation(s) with whom they intend to or do undertake either voluntary or paid work and seek the case manager's consent to undertake such work. The medical practitioner should be reminded of his or her contractual obligations but would be given 24 hours' notice to return to work. The medical practitioner must apply for annual, study and any other leave in the normal way. If the medical practitioner is ill and unable to attend for work he or she should inform the Trust in the normal way (by self-certification and medical practitioners notes). In exceptional circumstances the case manager may decide that payment is not justified because the medical practitioner is not available for work due to absence without authority. This in itself may result in disciplinary action.

2.29. The case manager should make arrangements to ensure that the medical practitioner can keep in contact with colleagues on professional developments, and take part in Continuing Professional Development (CPD) and clinical audit activities with the same level of support as other medical practitioner in the Trust's employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

Informing other organisations

2.30. In cases where there is concern that the medical practitioner may be a danger to service users, the Trust may consider that it 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 medical practitioner must 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 service users. Where the Trust has placed restrictions on practice, the medical practitioner must agree not to undertake any work in that area of practice with any other employer or on a self-employed capacity. If in doubt, the practitioner must seek and obtain prior consent from the Case Manager to continue or commence such work.

2.31. Where the case manager believes that the medical practitioner is practicing 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.

Informal exclusion

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

Keeping Exclusions and Restrictions Under Review: Informing the Board

2.33. The Board must be informed about exclusions and restrictions on practice at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed. Therefore:

- An anonymous summary of the progress of each case at the end of each period of exclusion or restriction on practice will be provided to the Board, demonstrating that procedures are being correctly followed and that all reasonable efforts are being made to bring the situation to an end as quickly as possible;
- A monthly statistical summary showing all exclusions with their duration and number of times the exclusion/restriction had been reviewed and extended.

Regular Review

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

2.35. 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 service users, other staff, the medical practitioner, and/or the needs of the investigative process continue to necessitate exclusion or restriction on practice and give full consideration to the option of the medical practitioner returning to full, limited or alternative duties where practicable.

2.36. The Trust must take review action before the end of each 4 week period. After three exclusions, PPA must be called in. The information below outlines the activities that must be undertaken at different stages of exclusion or restriction on practice.

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

2.37. Before the end of each exclusion or restriction on practice (of up to 4 weeks) the case manager must review the position.

- The case manager decides on next steps as appropriate, taking into account the views of the medical practitioner. A further renewal may be for up to 4 weeks; The case manager submits an advisory report of outcome to Chief Executive and the Trust Board;
- Each renewal is a formal matter and must be documented as such;
- The medical practitioner must be sent written notification on each occasion.

Third review

2.38. If the medical practitioner has been excluded or had restrictions placed on his/her practice for three periods:

- A report must be made to the Chief Executive outlining the reasons for the continued action and if the investigation has not been completed, a timetable for completion of the investigation.
- The Chief Executive must then report to the designated Board member (see paragraphs 2.43-2.45).
- The case must formally be referred to PPA explaining why continued exclusion or restriction on practice is appropriate and what steps are being taken to conclude the exclusion or restriction on practice, at the earliest opportunity.
- PPA will review cases of continued exclusion or restriction and advise the Trust on the handling of all cases until they are concluded.

6 months review

2.39. If the exclusion or restriction on practice has been extended over six months:

- In cases of continued exclusions, a further position report must be made by the Chief Executive to the Board indicating the reason for continuing the exclusion, the anticipated time scale for completing the process and the actual and anticipated costs of exclusion. In the case of continued restrictions on practice a further position report must be made by the Chief Executive to the Designated Board Member;
- In cases of continued exclusions, the Board will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can seek in order to expedite the process, including the convening of a panel as set out in 2.40 below.

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

Appeal

2.41. At any stage when a medical practitioner is excluded or has restrictions placed on their practice, they may appeal to a panel convened by the Trust. Once an appeal has been heard, the medical practitioner will not be allowed to appeal again for a period of 3 months. The panel will consist of a Trust Executive Director appointed by the Medical Director (to chair the panel), a consultant appointed by the Medical Staff Committee and a third member from the same specialty and grade as the medical practitioner from outside the Trust. The panel will recommend to the Chief Executive whether the exclusion or restriction on practice should continue or be lifted.

The role of the Board and designated member

2.42. Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review.

2.43. The Board is responsible for designating one of its non-executive members as a “designated Board member" under these procedures. The designated Board member is the person who oversees the case manager and case investigator during the investigation process and maintains momentum of the process.

2.44. This member's responsibilities include:

- Receiving reports and reviewing the continued exclusion from work or restriction on practice;
- Considering representations from the medical practitioner about his or her exclusion or restriction on practice;
- Considering any representations about the investigation.

Return To Work

2.45. If it is decided that the exclusion or restriction on practice should come to an end, there must be formal arrangements for the return to work or, in the case of restrictions on practice, full duties of the medical 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 service user safety.

3. CONDUCT AND DISCIPLINARY MATTERS

Introduction

3.1. Misconduct matters for medical practitioners, as for all other staff groups, are dealt with under the Trust’s Disciplinary Policy. However, where any concerns about the performance or professional conduct of a medical practitioner are raised, the Trust will contact the PPA for advice before proceeding.

3.2. Where the alleged misconduct being investigated under the Trust's Disciplinary Procedure relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must formally involve an appropriate medical practitioner to provide independent professional advice with a medical practitioner nominated by the Medical Director in consultation with the Chair of the Medical Staffing Committee. Where no suitable medical practitioner is employed by the Trust, a medical practitioner from another Trust should be involved. The medical practitioner will be expected to contribute to the investigation process and maybe required to attend if any of the panel members require this. The Trust will agree on the selection of the medical panel members.

3.3. The Trust's Disciplinary Procedure sets out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules are considered to be "misconduct". Examples of gross misconduct for all categories of staff are set out in the Trust Disciplinary policy for all employees.

3.4. The Trust will consult where necessary with PPA and its own employment solicitors regarding the appropriateness of the using conduct or capability procedures. The medical practitioner is also entitled to use the Trust's grievance procedure if he or she considers that the case has been incorrectly classified. Alternatively, or in addition he or she may make representations to the designated board member.

3.5. In the event that a medical practitioner is issued with a final written warning in accordance with the Trust's Disciplinary Procedure, the warning will remain live for 12 months.

Action when investigations identify possible criminal acts

3.6. Where any allegations give rise to potential criminal allegations, the People Director should be consulted at the earliest opportunity. Police investigations are not necessarily a bar to continue internal investigations. However, if the police do not consent to the Trust continuing an investigation because it would prejudice their criminal investigation, the Trust must cease that investigation. In cases of fraud, the Local Counter Fraud & Security Management Service will be contacted.

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

3.7. There are some criminal offences that, if proven, could render a medical practitioner unsuitable for employment. In all cases, the Trust, having considered the facts, will need to consider whether the employee poses a risk to service users or colleagues and whether their conduct warrants an investigation and the exclusion or restriction of practice. The Trust will have to give serious consideration to whether the employee can continue in their job once criminal charges have been made. Bearing in mind the presumption of innocence, the Trust will consider whether the offence, if proven, is one that makes the medical practitioner 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 may be sought from the Trust' solicitors. The Trust will explain the reasons for taking any such action to the medical practitioner concerned.

Dropping of charges or no court conviction

3.8. When the Trust has refrained from taking action pending the outcome of a court case or police, or other investigation, if the medical practitioner is acquitted or action not pursued but the employer feels there is enough evidence to suggest a potential danger to service users, then the Trust has a public duty to take action and to conduct their own investigation. The Police may be approached to use evidence collected in their criminal investigation. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the medical practitioner concerned.

Terms of Settlement on Termination of Employment

3.9. In some circumstances, terms of settlement may be agreed with a medical practitioner if their employment is to be terminated. The following principles will be used by the Trust in such circumstances:

- Settlement agreements must not be to the detriment of service user safety
- It is not acceptable to agree a settlement agreement that precludes either appropriate investigations being carried out and reports made or referral to the appropriate regulatory body
- 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
- Expenditure on termination payments must represent value for money. For example, the Trust 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 the Trust or 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 district auditor and public scrutiny
- 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
- 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 Deed of Compromise that should set out what each party may say in public or write about the settlement. The Deed of Compromise is for the protection of each party, but it must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an open reference. For the purposes of this paragraph, an open reference is one that is prepared in advance of a request by a prospective employer

4. PROCEDURE FOR DEALING WITH ISSUES OF CAPABILITY

Introduction and General Principles

4.1. There will be occasions where the Trust considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues. Matters that should be described and dealt with as misconduct issues are covered in part 3 of this procedure.

4.2. Concerns about the capability of a medical practitioner may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from PPA will help the Trust to come to a decision on whether the matter raises questions about the medical practitioners capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, **the matter must be referred to PPA before the matter can be considered by a capability panel.** Failure to co-operate with a referral to PPA may be seen as evidence as a lack of willingness on the part of the medical practitioner to work with the Trust on resolving performance difficulties. If the medical 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 General Medical Council.

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

- Out of date clinical practice;
- Inappropriate clinical practice arising from a lack of knowledge or skills that puts service users at risk;
- Incompetent clinical practice;
- Inability to communicate effectively with colleagues and/or service users;
- Inappropriate delegation of clinical responsibility; Inadequate supervision of delegated clinical tasks; Ineffective clinical team working skills.

This is not an exhaustive list.

4.4. Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. The Improvement Plan Template which appears at Appendix K provides a structured approach to reporting progress against objectives. Early identification of problems is essential to reduce the risk of serious harm to service users. PPA will be consulted for advice to support the medical practitioner.

4.5. 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. The Trust will always consult with PPA and if necessary, its own employment lawyers regarding the appropriateness of the using conduct or capability procedures. The medical practitioner is also entitled to use the Trust's grievance procedure if they consider that the case has been incorrectly classified. Alternatively, or in addition he or she may make representations to the designated board member.

Duties of Employers

4.6. The procedures set out below are designed to cover issues where a medical practitioner's *capability* to practice is in question. Prior to instigating these procedures, the employer will consider the scope for resolving the issue through counselling or retraining or other method of resolution and will take advice from PPA.

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

4.8. 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, age, sexual orientation or religion.

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

The pre-hearing process

4.10. When the investigation report has been provided, the case manager must give the medical practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. The report will contain copies of the witness statements including one form the medical practitioner. If the medical practitioner admits to the allegations then mitigation would be detailed in that statement. If however, the medical practitioner did not give mitigating circumstances when making their statement but may wish to do so after having read the full report. There may be occasions where medical practitioners may not wish to plea mitigation unless and until the case is decided. If the allegations are proven the medical practitioner is able to still plea mitigation at the hearing.

The case investigators report 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 medical practitioner should be extended.

4.11. The case manager should decide what further action is necessary, taking into account the findings of the report and any comments which the practitioner has to make on the factual contents of the report. These comments should be received in writing from the medical practitioner or the representative within 10 working days of the date of receipt of the letter requesting comments. Advice from PPA should be sought. Where the medical practitioner is on annual leave, approved by the Trust and unable to respond by the deadline set by the Trust, the deadline should be extended.

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

4.12. PPA will assist the Trust in drawing up an action plan designed to enable the medical practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the medical practitioner before it can be actioned). There may be occasions where PPA may recommend an external educational or other action plan that is dependent on the willingness of another organisation to assist the Trust and the medical practitioner, and may involve significant cost to the Trust. It may be the case that the action plan could not be carried out due to the medical practitioner's personal circumstances. Where there are such practical difficulties the Trust will work with PPA to identify possible alternatives. There may be occasions when a case has been considered by the PPA, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by the PPA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

4.13. If the medical practitioner does not agree to the case being referred to the PPA, a panel hearing will normally be necessary.

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

- The case manager must notify the medical 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 medical 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 medical practitioner sufficient notice to allow them to arrange for a union representative or a colleague employed by the Trust to accompany them to the hearing if they so choose; The composition is outlined below in paragraph 4.16.
- 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 exceptional circumstances (where the new information makes a material difference to the evidence being presented) and for complex cases or due to annual leave, the deadline for comments from the medical practitioner should be extended. The case manager should consider whether a new date should be set for the hearing.
- Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not less than 30 working days), to proceed with the hearing in the medical practitioner's absence, although the Trust will act reasonably in deciding to do so, taking into account any comments made by the medical practitioner;
- Should the medical practitioner's ill health prevent the hearing taking place the Trust will operate in accordance with the Managing Absence Policy and involve Occupational Health as necessary;
- Witnesses who have made written statements at the inquiry stage will be required to attend the capability hearing. The Chairman of the panel cannot require anyone other than the 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;

The hearing framework

4.15. The Medical Director/Case Manager is responsible for appointing the panel. The capability hearing will be chaired by an Executive Director of the Trust. The panel will comprise of a total of 3 people, normally two members of the Trust Board or Clinical/Service Director appointed by the Board for the purpose of the hearing. At least one member of the panel must be a medical practitioner at Consultant level who is not employed by the Trust. This person must be from a psychiatry speciality. The Trust will agree the external medical practitioner with the chair of the Medical Staffing Committee. No member of the panel or advisers should have been previously involved in carrying out the investigation. Arrangements must be made for the panel to be advise by a Human Resources representative and a medical practitioner from the same or similar clinical speciality as the practitioner concerned but from another NHS employer. The Trust will appoint the panel. Where a capability hearing is relating to an Academic staff employee, the panel must include a University rep, not necessarily from the same speciality, as agreed by the PG Dean and the Medical Director.

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

- A Human Resource representative
- A Consultant medical practitioner from the same or similar clinical speciality as the medical practitioner concerned, but from another NHS employer

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

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

Representation at capability hearings

4.18. The medical 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.

4.19. The medical practitioner may be represented in the process by a recognised member of a trade union, defence organisation or a colleague employed by Sheffield Health and Social Care NHS Trust. Such a representative may be legally qualified, but they will not be representing the medical practitioner in a legal capacity. The representative will be entitled to present a case on behalf of the medical practitioner, address the panel and question the management case and any witness evidence.

Conduct of the capability hearing

4.20. The hearing should be conducted as follows:

- The panel and its advisers (see paragraph 4.16), the medical practitioner, his or her representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- The Chair of the panel will be responsible for the proper conduct of the proceedings. The Chair should introduce all persons present and announce which witnesses are available to attend the hearing;
- 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 late evidence agreed to be admitted;
- The method of the confirmation of any written statement will be agreed by the panel and medical practitioner from the outset. ○ 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.

4.21. The order of presentation shall be:

- The Case Manager presents the management case including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall leave;
- The Chair shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.
- The medical practitioner and/or their representative shall present the practitioners 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 leave;
- The Chair shall invite the medical practitioner and/or representative to clarify any matters arising from the practitioner’s case on which the panel requires further clarification;
- The Chair shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- The Chair shall invite the medical practitioner and/or representative to make a brief closing statement summarising the key points of the medical practitioner’s case. Where appropriate this statement may also introduce any grounds for mitigation which have not been previously been disclosed (see paragraph 4.11)
- The panel shall then retire to consider its decision.

Decisions

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

- No action required;
- Informal action such as training or other development, team development or mentoring in the form of an action plan
- Verbal warning and written details of required improvement in clinical performance within a specified time scale and how it might be achieved [stays on the practitioner's record for 6 months];
- Written warning and written details of required improvement in clinical performance within a specified time scale and how it might be achieved [stays on the practitioner's record for 1 year];
- Final written warning and written details of and written details of required improvement in clinical performance within a specified time scale and how it might be achieved [stays on the medical practitioner's record for 1 year] •
- May include demotion and redeployment if the practitioner has other skills.
- Termination of contract

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the medical 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 may wish to comment on.

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

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

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

Appeals in Capability Cases

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

- A fair and thorough investigation of the issue;
  - Sufficient evidence arising from the investigation or assessment on which to base the decision;
  - Whether in the circumstances the decision was fair and reasonable, and commensurate with the evidence heard.

It can also hear new evidence submitted by the medical practitioner and consider whether it might have significantly altered the decision of the original hearing. This may be evidence which was submitted late and not accepted or was available before the first hearing but not submitted. The appeal panel, however, should not rehear the case in its entirety (but in certain circumstances it may order a new hearing see 4.30).

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

The appeal process

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

4.29. The appeal panel can hear any new evidence submitted by the practitioner to consider whether this might have significantly altered the capability panel's decision. The case manager may call new evidence that is relevant to the new evidence called by the medical practitioner and/or their representative.

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

The appeal panel

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

- An independent member (trained in legal aspects of appeals) from an approved pool. This person will be appointed from the national list held by NHS Employers for this purpose. This person is designated Chairman;
- The Chairman (or other non-executive director) of the employing organisation who must have the appropriate training for hearing an appeal;
- A medically qualified member who is not employed by the Trust who must also have the appropriate training for hearing an appeal, medical practitioner with the Local Negotiating Committee/Medical Staffing Committee.

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

- A Consultant Practitioner from the same specialty or subspecialty as the appellant, but from another NHS employer
- A Human resources specialist who may be from another NHS organisation.

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

4.33. The case manager should make the arrangements for the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 4.35. The practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The Trust will review the situation and take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved. The Trust must provide the medical practitioner with the reasons for reaching its decision in writing before the hearing can take place.

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

- Appeal by written statement to be submitted to the designated appeal point (normally the Human Resources Director within 25 working days of the date of the written confirmation of the original decision;
- Hearing to take place within 25 working days of date of lodging appeal;
- Decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing.

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

Powers of the appeal panel

4.36. 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.

4.37. 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.

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

the appeal, or whether the case should be reheard, on the basis of the new evidence, by a capability hearing panel.

Conduct of appeal hearing

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

4.40. The medical practitioner may be represented by a recognised member of a trade union, defence organisation or a colleague employed by Sheffield Health and Social Care NHS Trust. The representative will be entitled to present a case on behalf of the medical practitioner, address the panel and question the management case and any evidence.

4.41. 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 representative) can at this stage make a statement in mitigation.

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

Decision

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

Action following hearing

4.44. Records must be kept, including a report detailing the capability issues, the medical 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 2018 (any relevant Trust information governance procedures. These records need to be made available to those with a legitimate call upon them, such as the medical practitioner, the Regulatory Body, or in response to a Direction from an Employment Tribunal.

Termination of Employment with Performance Issue Unresolved

4.45. Where an employee leaves employment before disciplinary procedures have been completed, any outstanding disciplinary investigation will be concluded, and capability proceedings will be completed where possible.

4.46. Where employment ends before investigation or proceedings have been concluded, every reasonable effort will be made to ensure the former employee remains involved

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

4.47. If an excluded employee or an employee facing capability proceedings becomes ill, they will be subject to the Trust's Promoting Attendance and Managing Absence Policy. The sickness absence procedures take precedence over the capability procedures and the Trust will take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 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 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 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.

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

4.49. Where a case involves allegations of abuse against a child, the guidance issued to the NHS in September 2000, called "The Protection of Children Act 1999 – A Practical Guide to the Act for all Organisations Working with Children" gives more detailed information. A copy can be found on the Department of Health website: (***www.dh.gov.uk/PublicationsAndStatistics***).

4.50 Where a case involves allegations of abuse against a vulnerable adult, the guidance issued by the Department of Health in March 2000, called "No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" gives more detailed information. A copy can be found on the Department of Health Website (***www.dh.gov.uk/PublicationsAndStatistics***). The Trust also has its own Adult Abuse Joint Policy and procedures.

5. HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH

Introduction

5.1. A wide variety of health problems can have an impact on an individual's clinical performance.

5.2. The Trust's key principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be redeployed, re-trained, given support in accessing rehabilitation and kept in employment.

Retaining the services of individuals with health problems

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

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

This is not an exhaustive list

Reasonable adjustment

5.4. At all times the medical practitioner will be supported by the Trust and the Occupational Health Service (OHS) which will ensure that the medical 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 or other arrangements, in line with the Equality Act. It will consider:

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

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

Handling Health Issues

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

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

5.8. The Occupational physician should agree a course of action with the medical practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the People Director, the Medical Director or case manager, the medical practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate) The medical practitioner may wish to bring a support companion to these meetings. This could be a colleague, a representative from a recognised trade union or defence association of which the practitioner is a member. Confidentiality must be always maintained by all parties.

5.9. If a medical practitioner's ill health makes them a danger to service users and they do not recognise that, or are not prepared to co-operate with measures to protect service users, 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.

5.10. 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 the OHS or the PPA. In these circumstances the procedures in part 4 should be followed.

5.11. There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the medical practitioner to the OHS 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.

Signed……………………….……………(on behalf of the Trust) Date …………………….

Signed……………………………(on behalf of the LNC) Date………………………………..

APPENDIX A

Definitions of key roles

"Case Manager" is the person who has responsibility for overseeing investigations into concerns about a medical practitioner. His/her duties are to:

- On first hearing about these concerns needing to decide whether they should be formally investigated.
- Notify the medical practitioner in writing of such investigation.
- Consider (usually with the Director of Human Resources and Chief Executive) whether to immediately restrict a medical practitioner's duties or exclude him/her from work or take some other form of protective action.
- Upon receipt of the case investigator's report consider whether a formal procedure should be started (for instance a disciplinary hearing). At this stage, he/she will also consider whether any immediate restrictions or exclusion should be continued.
- Review any exclusion and determine after careful thought whether it should be continued.
- Prepare reports on each exclusion before the end of each four-week exclusion period.
- Liaise with and seek the advice of the PPA as set out in this policy.

"**Case investigator"** is the person who is responsible for carrying out a formal investigation into concern(s) about a medical practitioner. He/she:

- Must carry out a proper and thorough investigation into the concerns.
- Involve an appropriately qualified clinician to investigate clinical concerns if he/she does not have such qualifications.
- Ensure that appropriate witnesses are interviewed and evidence reviewed.
- Ensure that any evidence gathered is carefully and accurately documented.
- Keep a written record of the investigation, the conclusions reached and the course of action agreed with the Medical Director.
- Meet with the medical practitioner in question to understand the practitioner's case.
- Prepare a report at the conclusion of the investigation providing the case manager with enough information to decide how to take it forward.
- Provide updates and assistance to the Designated Board Member on the progress of the investigation.
- Provide factual information to assist the case manager in his/her review of any exclusion.

"Designated Board Member" is a non-executive director of the Trust who ensures that the processes set out in these guidelines are being followed but does not make decisions on any issues such as whether to exclude from work. He/she:

- Ensures that the investigation is being carried out promptly and in accordance with these guidelines.
- Acts as a point of contact for the medical practitioner, making him/herself available after due notice if the medical practitioner has significant concerns about the progress of the investigation or any exclusion from work.

"Clinical Adviser" is the person who provides clinical advice and guidance to the case investigator if relevant where clinical issues arise. He/she will have appropriate specialist skills to advise. Where no such person is available or is precluded from advising (for instance if he/she raises the concerns) the Trust will seek to identify a person outside its employment to advise.

“Responsible Officer” is a senior doctor who is appointed by a healthcare organisation to discharge responsibilities under the Medical Profession (Responsible Officers) Regulations 2010. Those responsibilities include ensuring that the organisation carries out regular appraisals of medical practitioners; establishing and implementing procedures to investigate concerns about a medical practitioner’s fitness to practise; where appropriate, referring a medical practitioner to the GMC; and making recommendations to the GMC about a medical practitioner’s fitness to practise.

APPENDIX B

Authorisations

Employees with the power to exclude medical practitioners from work or restrict their practice

The following are authorised to exclude or restrict practice: the Chief/ Deputy Chief Executive, the Medical/Deputy Medical Director. Clinical Managers or ,where the appropriate Clinical Manager is not available, the People Director (for medical practitioners below the grade of consultant).

APPENDIX C

AUTHORITY TO SANCTION

This section below identifies those managers authorised to take disciplinary action in accordance with the policy.

1. Verbal warnings

The authority to issue a verbal warning rests with the investigating manager's manager (or appropriate equivalent) responsible for direct or indirect management of the individual.

2. First written warning/final written warning

The authority to take this level of action will be within the remit of those managers holding Clinical Director posts or above.

3. Dismissal/disciplinary transfer/demotion

The authority to dismiss (or transfer or demote where dismissal of the medical practitioner can be justified) will be within the remit of the Chief Executive, Executive Directors and, with the Executive Director's authorisation, those who report directly to them e.g. Service Director, Clinical Director or equivalent.

NB: *In all cases, an appropriately equivalent manager may be a manager of an equivalent status from another directorate.*

APPENDIX D

REMEDIATION

Remediation is defined as
the overall process agreed with a practitioner to redress identified aspects of underperformance (knowledge, skills and behaviours). Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation.

The Trust has in place a document entitled “Disciplinary, Capability, Ill Health and Appeals Policies and Procedures for Medical Practitioners”. This document sets out how issues of serious concern regarding the performance of doctors will be considered. This remains the primary document by which any serious issues will be considered including those relating to remediation.

The need for a robust and consistent approach to remediation is independent of the new regulatory process of revalidation that is being introduced by the GMC for all licensed doctors. However, improved clinical governance and the annual appraisal processes which will underpin revalidation may mean that, at least in the short-term, more doctors are identified who have a clinical competence and capability issue, and are in need of remediation. Responsible Officers have a responsibility to establish and implement procedures to deal with questions concerning a doctor’s fitness to practice. In the case of clinical academics, there will be a need to establish arrangements with the University where this is relevant and appropriate.
It also needs to be recognised that it has been set out nationally that there remain weaknesses in how performance issues are addressed. These include:

- major problems often surface as a serious incident when they have been known about in informal networks for years;
- over-reliance is placed on disciplinary solutions to problems late in the day, whilst mechanisms to produce earlier remedial and educational solutions are particularly weak. Often the human resource function is not involved until disciplinary proceedings are unavoidable;
- NHS trusts and health authorities are often deterred from taking action because the disciplinary processes are regarded as daunting and legalistic;
- there is no clarity at local level about the interface between GMC procedures and NHS procedures so that there is confusion about who does what and when;
- mechanisms to identify and help sick doctors are unsatisfactory;

- in the past, too many problem doctors have been moved on to become another employer's problem rather than being dealt with; and
- the timescales for dealing with serious problems can be very protracted and often last months or even years.

Source: Supporting doctors protecting patients 1999

Concerns about a doctor's practice must be addressed early, systematically and proactively. Good processes that deal with concerns as they arise and systems that support doctors to address their problems have been shown to minimise the need for restriction/ exclusion and a full remediation programme.

Aims of Remediation

Getting doctors back to full and unsupported medical practice is the aim of remediation. Implementation of planned and managed remedial programmes will support doctors in staying on their career path, and will contribute to the delivery of safe, high quality care to patients. However, whilst the ambition will be to get the doctor back to their previous role it must be recognised that this will not always be possible. There will be occasions when, despite all best endeavours, it will be necessary to conclude that a doctor should no longer practice and that remediation cannot be achieved, Patient safety will always be paramount.

General Principles for Remediation

These principles can be summarised as:

- Patients must be protected.
- All action must be based on reliable evidence.
- The process must be clearly defined and open to scrutiny.
- The process should demonstrate equality and fairness.
- All information must be safeguarded.
- Support must be provided to all those involved.

Account will also be taken of the Recommendations set out in the Department of Health Report
„Tackling Concerns Locally". However, whilst these recommendations are helpful it was noted by the Steering Group on Remediation set up subsequently by the Department of Health that in practice some of them would be difficult and expensive to achieve.

The Report and Recommendations on Remediation and Revalidation by the Academy of Medical Royal Colleges is also available as a source of reference, including case studies.

Role of Appraisal

Whilst essentially developmental in nature, appraisal discussions can surface issues about areas of work where there are competency problems, and where action needs to be taken. Personal development plans should include actions to remedy any minor performance issues. Better performance data and clinical governance systems should help to produce objective evidence to both highlight concerns and aid review during the investigation of concerns.

Stages of Remediation

- Identifying concerns;
- Investigation;
- Deciding on action; and
- Remediation – re-skilling and rehabilitation

There is a large continuum of clinical competence and capability issues, from minor concerns that may be resolved through the annual appraisal and personal development plan process, to issues that may require a very comprehensive training package and external assistance.

Identifying concerns

In the course of their professional career every doctor will experience variation in the level of their practice, and clinical competence. Every doctor will make mistakes and, on occasion, patients will come to harm as a result. All doctors must therefore be vigilant in recognising, and taking responsibility for mistakes and for reductions in the quality of their practise. Learning from these will improve patient safety in the future.

A concern about a doctor's practice can be said to have arisen where an incident causes or has the potential to cause, harm to a patient, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with those standards. There will be different levels of severity in the concerns identified careful analysis of the severity of the concern will guide an appropriate response.

The GMC has issued guidance to doctors on
-raising concerns, which gives advice on raising a concern that patients may be at risk of harm
-acting on a concern, which explains doctor's responsibilities when colleagues or others raise concerns with them and how these concerns should be handled.

The immediate task for a Medical Director when a concern comes to light is to determine whether there are any urgent safety concerns relating to patients, staff or the doctor about whom the concern has been raised. He/she will need to decide, based on the information available, whether the doctor's practice be restricted or they should be excluded immediately pending formal investigation. (See Section 2 of Policy)

Investigating a Concern

Once a concern is recognised and raised with the Medical Director, they will be responsible for making an initial assessment and a decision on whether an investigation should take place. Concerns about a doctor's practice can be separated into three categories: conduct, capability and health. There is often considerable overlap between these categories and concerns may arise from any combination, or all three of these. An investigation will clarify the nature of the concern, confirm the facts, establish its severity and give an indication of the appropriate response.

Any serious concerns would be considered within the context of the Trust's Policy "Disciplinary, Capability, Ill Health and Appeals Policies and Procedures for Medical Practitioners."

Reference may also be made to *How to Conduct a Local Performance Investigation* (NCAS, 2010)

Deciding on Action

This again would be determined in accordance with the Trust's Policy.

The Responsible Officer will need to decide whether the issue can be resolved within the organisation, either through discussion with the doctor concerned or through formal procedures. They will also need to decide whether others should be consulted, informed and involved in the process and, which bodies, if any, should be called upon to assist in this. It may be that immediate referral to the regulator or the police is required.

The Responsible Officer will also need to consider which other factors need to be taken into consideration, for example, a concern affecting not only one individual but a clinical team or the wider organisation.

Where Remediation is Appropriate

The most common types of interventions identified by designated bodies are listed below.

Supervision:

- supervised practice.
- formative work-based assessments.
- case-based reviews, mini-clinical evaluation exercises (Mini-CEX), objective structured clinical examinations (OSCE), on-site assessment and training (OSAT), video recording, simulation, patient and colleague feedback.

Development:

- educational activities
- re-training and re-skilling activities including tutorials, workshops, courses, e-learning, focused reading, language/communication skills-based activities.
- specialist interventions.
- behavioural coaching, occupational, psychological and specialist health.
- (mental health and addiction) interventions, counselling (career or therapeutic), boundary awareness, cultural competence.
- practitioner support
- mentoring, vocational rehabilitation, protected learning and development time, career guidance, financial advice
- other organisational support
- team or workplace mediation

Scope of work:

- amendment / restriction of aspects of scope of work.

A written remediation plan should be accepted by both parties which includes the details, location, terms, review periods / timescales of the remediation. There should be a formal sign off when complete and progress/outcome should be included in the appraisal process. Appendix K may be used for this purpose, modified as necessary. Advice and/or a referral will be sought from PPA as set out in the Policy.

Where there has been an incident that points to a problem with a doctor's health, the provisions of Section 5 of the Policy should be applied.

Formal or informal action

Cases involving minor misconduct or early indications of unsatisfactory performance may be handled informally e.g. additional training, coaching or advice. There should be a two-way discussion of the issues and clear goals set where improvement is required.

If informal action does not bring about sufficient improvement or if the matter is considered too serious to be classed as minor then it should be made clear to the employee that formal action will be necessary. Informal action should not, without notice to the doctor, turn into formal disciplinary action. If during an informal discussion it becomes clear that the matter may be more serious then the meeting should be adjourned and the matter referred via the formal Trust processes.

"Off the record" informality between clinical managers and doctors need to be considered very carefully as they often do not resolve concerns and may make them more difficult to handle effectively. Such discussions do not discharge responsibility.

Conduct, capability or ill-health

Concerns will need to be categorised as far as practicable. Early identification of the problem underlying the concern will help in determining the most effective course of action. However, in each area one of the potential outcomes could be to enter a local remediation process.

In accordance with Paragraph 4.4 of Section 4 of the Policy, where 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.

Sometimes categorisation may be difficult. e.g. concerns about attitude, behaviour and communication. Where these matters directly affect the four key domains of Good Medical Practice (Knowledge, skills performance/ Safety and quality /Communication, partnership and teamwork/Maintaining trust) they should be managed as a capability issue. The formal procedure for handling concerns is set out in the Trust document referred to above.

Early Intervention

The earlier that concerns are identified, discussed and resolved the better. Interventions such as training, mentoring, shadowing, and extra supervision may be able to be deployed quickly. The aim should be to deal with shortcomings at the very earliest opportunity. Where concerns are observed directly it can be relatively straightforward to intervene to demonstrate better approaches to the work there and then. Alternatively, other opportunities for reflective learning should be used.

A number of triggers may alert the Medical Director such as a significant event or a series of complaints. Often one concern or event will prompt the Medical Director to examine other available data, but low-level concerns revealed by data in different areas should be

triangulated with data from other sources to allow earlier intervention before a more serious concern occurs.

Remediation and recruitment

The Trust will seek to reduce performance issues by:

- effective recruitment procedures and processes;
- initiating six-monthly reviews in the first two years following appointment to a career grade;
- mentorship for the first two years for doctors newly recruited to career grade posts;
- effective induction processes that include responsibility to raise concerns about colleagues‟ practice and how performance issues are managed.

Responsibilities

The *individual doctor* has a personal responsibility for their conduct, clinical competence and capability and to:

- ensure that they are working to Good Medical Practice and other relevant GMC guidance;
- work within the relevant specialty framework;
- meet any employment or contractually-related related standards for their current role;
- be honest about when they feel that they might have clinical competence and capability problems and seek early help and support; and
- engage constructively with their employer or contracting body when problems are identified.

Once a concern is raised, *the Trust* will:

- tackle concerns promptly, ensuring the primacy of patient safety;
- fully assess concerns so that appropriate action is taken, following the relevant process;
- refer regulatory matters to the relevant body in parallel with local processes (the GMC liaison service is able to advise. Any referral to the GMC should be made by the Trust's RO, after discussion with the Medical Director and GMC ELA)
- fully involve, as appropriate to the seriousness of the issue, both the Human Resources
- Director and Medical Director who should together lead the process;
- follow an appropriate competent investigation process, including investigation into whether there are organisational issues that need to be addressed;
- maintain good documentation and record keeping throughout the process; assess the need to keep patients up-to date, whilst respecting the appropriate confidentiality of the individual concerned;
- ensure the Medical Director/ and the Human Resources Director work together to oversee the processes, including reviewing whether there are organisational problems that also need to be addressed;
- make it clear to a doctor who requires remediation what they must achieve before they commit to a programme. This should include clear boundaries, the method to be used for remediation, how they will be able to demonstrate that they have been remediated,

how and who will assess whether they have successfully completed the programme, and the proposed timescale;

- ensure that where a doctor causing concern has been recently appointed and promoted, there will be liaison with the relevant Postgraduate Dean to ensure there are no systemic failures in the deanery selection and assessment processes;
- ensure there is a clear exit strategy for any remediation case;
- ensure the remediation process is confidential as far as is practicable.

Liaison with BMA /Defence bodies

As indicated above, early and effective remediation will crucially be dependent on the individual doctor's willingness to engage constructively in the process. Where appropriate this will involve liaison with the BMA and/or defence bodies on an informal basis to establish the approach which may be most appropriate to the circumstances. Any actions taken forward would, however, be part of a formally structured consideration.

Monitoring and evaluation

It is important for the Medical Director and Trust to understand the local picture of concerns so that appropriate resources can be allocated, and also to understand whether the organisation is experiencing a higher level of concerns than may be expected. The Medical Director will monitor the concerns relating to the doctors for whom they are responsible and report their findings to the Revalidation Steering Group.

The Medical Director may also, as appropriate, compare levels of concerns with other organisations: sharing experiences through responsible officer networks will allow consideration of the handling of concerns within their own organisation. This will also enable consideration of whether organisational factors are impacting on the performance of the doctors who work for them and what steps could be taken to alleviate any pressures or difficulties.

The Medical Director may therefore wish to identify a dataset of items that will enable effective monitoring and comparison of the level of concerns. This may include, for example, gender, specialty and career grade, and the nature, category and level of the concern.

The RST has developed *Information Management for Medical Revalidation in England* (RST, 2012), a separate guidance document relating to information storage, sharing and governance. In particular Medical Directors will find it helpful to:

- keep accurate and timely records of all discussions relating to a concern
- inform all those concerned that records of discussions will be kept
- store records securely, and inform the doctor concerned as to the content of the records that are being kept
- share information collected by the responsible officer for monitoring a doctor's performance and fitness to practise with the doctor for inclusion in their portfolio and discussion at appraisal
- share relevant information appropriately with other parties, in particular the new responsible officer, should the doctor move to a different job
- ensure documentation is processed and managed in compliance with the requirements of the data protection legislation and the *Freedom of Information Act 2000.*

APPENDIX E

LIAISON WITH NHS ENGLAND AND THE JOINT PARTNERSHIP BOARD

The Trust recognises that there may be circumstances where it would be appropriate for the operation of the remediation and/or disciplinary procedures for the Trust to endeavour to liaise with appropriate representatives of NHS England in respect of salaried General Practitioners employed by the Trust.

Liaison may occur on any or all of the following:

- the implications for patient care arising from restriction of practice/exclusion or any other such preventative measures being considered by the Trust
- the implications for patient care arising from any measures being considered by NHS England affecting ability to practice
- the proposed terms of reference of any disciplinary investigation either by the Trust or NHS England
- the appointment of an appropriate Case Investigator and/or Clinical Adviser
- further action by the Trust and/or NHS England following the receipt of the Case Investigator's report
- actions relating to the remediation process

(The above list is not intended to be exhaustive)

The Trust will appoint its own Case Manager independently of any Case Manager appointed by NHS England. It will be responsible, as the employer, for any disciplinary action taken.

The Trust may also liaise with other relevant bodies such as the Joint Partnership Board. This liaison will be in respect of the implications for service delivery arising from the operation of the procedure.

The Trust will treat any such liaison on a confidential basis and only divulge such information as is deemed appropriate for the proper operation of this procedure.

Dissemination, storage and archiving (Control)

Version	Date on website (intranet and internet)	Date of "all relevant SHSC staff" email	Any other promotion/ dissemination (include dates)
4.0	October 2021	October 2021	Communication to all doctors within the Trust to explain reason for policy amendment.

9 Audit, Monitoring and Review

Monitoring Compliance Template

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Letter to current and new medical professionals	Audit	JLNC	Annual	JLNC	JLNC	People Committee

10 Implementation Plan

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
Communicate to all medical professionals and HR	Medical Director/People Director	31 October 2021	
Workshops for investigating managers/case managers	HRBP	Every 12 months	
Upload on Jarvis	HRBP	October 2021	

11 Dissemination, Storage and Archiving (Control)

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
4.0	October 2021	October 2021	October 2021	Medical Newsletter

12 Training and Other Resource Implications

All case managers, case investigators and HR will receive training before being involved in implementing this Policy. This will include Equality and Diversity awareness, as well as an understanding of the procedure.

13 Links to Other Policies, Standards (Associated Documents)

Disciplinary Policy
Promoting Attendance and Managing Sickness Absence Policy
Grievance Policy
Capability

14 Contact Details

Title	*Name*	*Phone*	*Email*

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date:	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**	**Yes**	**No**
Disability	**No**	**Yes**	**No**
Gender Reassignment	**No**	**Yes**	**No**
Pregnancy and Maternity	**No**	**Yes**	**No**
Race	**No**	**Yes**	**No**

Religion or Belief	**No**	**Yes**	**No**
Sex	**No**	**Yes**	**No**
Sexual Orientation	**No**	**Yes**	**No**
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by: Debra Butterworth
Name /Date 21 September 2021

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	/
2.	Is the local Policy Champion member sighted on the development/review of the policy?	/
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	NA
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Yes
5.	Has the policy been discussed and agreed by the local governance groups?	Yes
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	MHPS/GMC
	Template Compliance	
7.	Has the version control/storage section been updated?	Yes
8.	Is the policy title clear and unambiguous?	Yes
9.	Is the policy in Arial font 12?	Yes
10.	Have page numbers been inserted?	Yes
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Yes
	Policy Content	
12.	Is the purpose of the policy clear?	Yes
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Yes
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Yes
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Yes
16.	Does the policy include any references to other associated policies and key documents?	Yes
17.	Has the EIA Form been completed (Appendix 1)?	Yes
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Yes
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Yes
20.	Is there a plan to i. review ii. audit compliance with the document?	Yes
21.	Is the review date identified, and is it appropriate and justifiable?	Yes