DISCIPLINARY AND CAPABILITY POLICY FOR MEDICAL AND DENTAL STAFF

Document Summary

This document outlines the procedure that should be followed when handling concerns about trust employed doctors and dentists conduct and 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.

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1 **SCOPE**

This Procedure applies to all Medical and Dental staff employed by Cumbria Partnership NHS Foundation Trust. It outlines the procedure to be followed when a concern is raised about a doctor or dentist.

The Trust ensures its commitment to fair and equitable treatment of all members of staff irrespective of age, gender, marital status, disability, race, colour, national/ethnic origins, religion or belief or sexual orientation in the utilisation of this Policy. For Trust’s responsibilities and commitments under the Equality and Human Rights legislation, please refer to the Trust’s Single Equality Scheme.

2 **INTRODUCTION**

This procedure outlines the employer’s process for handling concerns about doctors’ and dentists’ professional conduct and capability. In drafting this procedure the Trust has based its content on the framework set out in HSC 2003/012 ‘Maintaining High Professional Standards in the Modern NHS’, issued under the direction of the Secretary of State for Health.

3 **STATEMENT OF INTENT**

This procedure has largely adopted the guidance set out in HSC 2003/012 “Maintaining High Professional Standards in the Modern NHS”. However, in relation to matters involving concerns about doctors’ and dentists’ professional conduct and capability this document supersedes Maintaining High Professional Standards in the Modern NHS.

Individuals will be given help and support where appropriate to achieve acceptable levels of conduct and capability.

It is essential that appropriate and thorough investigations are carried out and that individuals are given the opportunity to present their case as well as have a right of appeal where appropriate.

Whilst addressing the particular facts and circumstances of individual cases, we will seek to act consistently where the situations are the same so that like cases are treated alike.

4 **DEFINITIONS**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>The Trust</td>
<td>Cumbria Partnership NHS Foundation Trust</td>
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<tr>
<td>The Board</td>
<td>Cumbria Partnership NHS Foundation Trust Board</td>
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<tr>
<td>NCAS</td>
<td>National Clinical Assessment Service</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<td>GDC</td>
<td>General Dental Council</td>
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<tr>
<td>DOCTOR</td>
<td>For the purposes of this procedure whenever “doctor” is mentioned it refers to both doctors and dentists.</td>
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<tr>
<td>Designated Board member</td>
<td>A non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure</td>
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that momentum is maintained and consider any representations from the practitioner about his or her exclusion or any representations about the investigation;

5 DUTIES

These are set out in the relevant section(s) of the Details of the Policy (Section 6)

6 DETAILS OF THE POLICY

This procedure has five separate elements:
- Part 1 Action when a concern arises
- Part 2 Restriction of practice and exclusion from work
- Part 3 Conduct and disciplinary matters
- Part 4 Procedure for dealing with issues of capability
- Part 5 Handling concerns about practitioners health

1 PART 1

ACTION WHEN A CONCERN ARISES

1.1 Introduction

1.1a The management of performance is a continuous process which is intended to identify problems. 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 patients harmed; and which need not necessarily require formal investigation or the resort to disciplinary procedures.

1.1b Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:
- Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff;
- Review of performance against job plans, 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 patients or relatives of patients;
- Information from the regulatory bodies;
- Litigation following allegations of negligence;
- Information from the police or coroner;
- Court judgements.

1.1c All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to verify the facts so that the allegations can be shown to be true or false. Unfounded and malicious allegations can cause lasting damage to a doctor’s reputation and career prospects.
1.2 Procedure for managing Concerns

1.2a All serious concerns must be registered with the Medical Director and he or she must ensure that a case manager is appointed. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director will need to work with the Lead Director for HR or delegated officer to decide the appropriate course of action in each case. The Medical Director will act as the case manager in cases involving associate medical directors, clinical directors and consultants and may delegate this role to an associate medical director, clinical director or equivalent in all other cases. The Medical Director is responsible for appointing a case investigator.

1.2b 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. Part 2 of this framework sets out the procedures for this action.

1.2c The duty to protect patients is paramount. At any point in the process where the case manager has reached the clear judgment that a practitioner is considered to be a serious potential danger to patients or staff or whose behaviour undermines public confidence in the profession, that practitioner must be referred to the GMC/GDC, whether or not the case has been referred to the National Clinical Assessment Service (NCAS). Advice from the Employer Liaison Advisor (ELA), GMC should be sought in relation to the practitioner before any referral to the GMC is made. Consideration should also be given as to whether it is necessary to request the issue of a Healthcare Professional Alert Notice (HPAN).

1.3 Involving the NCAS

1.3a At any stage of the handling of a case, consideration will be given to the involvement of the NCAS. NCAS has developed a staged approach to the services it provides NHS Trusts and practitioners. This involves:
   - immediate telephone advice, available 24 hours
   - advice, then detailed supported local case management
   - advice, then supported local clinical performance assessment
   - advice, then detailed NCAS clinical performance assessment
   - support with implementation of recommendations arising from assessment
   - understanding the issue and investigation

1.4 Understanding the issue and investigation

1.4a Initially it should be clarified what has happened and the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures.
Key actions that are required are:

- Medical Director to discuss with the Lead Director for HR or delegated officer and the NCAS what the way forward should be
- Consider whether restriction of practice or exclusion is required
- If a formal approach under the conduct or capability procedures is required, appoint an investigator in accordance with appendix 1 and the Trust policy for disciplinary investigations.
- If the case can be progressed by mutual agreement, consider whether an NCAS assessment would help clarify the underlying factors that led to the concerns and assist with identifying the solution.

1.4b The first stage of the NCAS’s involvement in a case is exploratory – an opportunity for local managers to discuss the problem with an impartial outsider, to look afresh at a problem, see new ways of tackling it themselves possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

1.4c Having discussed the case with NCAS, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen, NCAS can still be involved with the problem until resolved. This can include NCAS undertaking a formal clinical performance assessment when the doctor, the Trust and NCAS agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps. If NCAS is asked to undertake an assessment of the doctor’s practice, the outcome of the local investigation may be made available to inform NCAS’s work.

1.4d 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 with the Lead Director for HR or delegated officer, appoint an appropriately experienced or trained person as case investigator and a designated Board member. The seniority of the case investigator will differ depending on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained, to enable them to carry out this role when required.

1.4e The case investigator:

- Is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings;
- Must formally involve a senior member of the medical or dental staff where a question of clinical judgment is raised during the investigation process. (Where no other suitable senior doctor or dentist is employed by the Trust a senior doctor or dentist from another NHS body should be approached);
- Must ensure that safeguards are in place throughout the investigation
so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but any disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered. The investigator will approach the practitioner concerned to seek views on information that should be collected;

- Must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene any disciplinary panel.
- Must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Lead Director for HR or delegated officer with the Medical Director;
- must assist the designated Board member in reviewing the progress of the case.

1.4f 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.

1.4g The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided, that an investigation is to be undertaken, the name of the case investigator and made aware of the specific allegations or concerns that have been raised. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied.

1.4h At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body; an official or lay representative of the British Medical Association, British Dental Association or a defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she must be either directly employed by the British Medical Association, British Dental Association or a defence organisation or directly instructed by the British Medical Association, British Dental Association or a defence organisation on behalf of the practitioner.

1.4i The case investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended 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 investigator must however agree a timetable with the case manager for when they envisage that the investigation will be completed.

1.4j If, during the course of the investigation, it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider whether an independent practitioner from another NHS body should
be invited to assist.

1.4k The case investigator should complete the investigation and submit their report to the case manager as soon as reasonably practicable. The report of the investigation should give the case manager sufficient information to make a decision whether:

- There is a case of misconduct that should be put to a conduct panel;
- There are concerns about the practitioner’s health that should be considered by the Trust’s Occupational Health Service;
- There are concerns about the practitioner’s performance that should be further explored by the NCAS;
- Restrictions on practice or exclusion from work should be considered;
- There are serious concerns that should be referred to the GMC or GDC;
- There are intractable problems and the matter should be put before a capability panel;
- No further action is needed.

1.5 Involvement of the NCAS following local investigation

1.5a Medical under-performance can be due to health problems, difficulties in the work environment, behaviour or a lack of clinical capability. These may occur in isolation or in a combination. NCAS’s processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. NCAS’s methods of working therefore assume commitment by all parties to take part constructively in a referral to the NCAS. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.

1.5b The focus of NCAS’s work is therefore likely to involve performance difficulties which are serious and/or repetitive. That means:

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

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

In cases where it becomes clear that the matters at issue focus on fraud, specific patient complaints or organisational governance, their further management may warrant a different local process such as remediation or disciplinary. NCAS may advise on this.

1.5c Where the Trust is considering excluding a doctor or dentist (whether or not his or her performance is under discussion with the NCAS), it is important for NCAS to know of this at an early stage, so that alternatives to exclusion are considered. Procedures for exclusion are covered in Part 2 of this procedure. It is particularly desirable to find an alternative when NCAS is likely to be involved, because it is much more difficult to assess a doctor who is excluded from practice than one who is working.

1.5d A practitioner undergoing assessment by the NCAS 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 NCAS assessment is complete. The NCAS has issued guidance on its processes, and how to make such referrals. This can be found at www.ncas.nhs.uk

Under Circular HSC 2002/011, Annex 1, paragraph 3, “a doctor undergoing assessment by NCAS 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”

1.5e Failure to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the employer on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the parties and may necessitate disciplinary action and consideration of referral to the GMC or GDC.

1.6 Confidentiality

1.6a The Trust and its employees will use its best endeavours to maintain confidentiality at all times. No press notice will be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The employer should only confirm publicly that an investigation or disciplinary hearing is underway.

1.6b Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose, nor disproportionate to the seriousness of the matter under investigation. The Trust will operate consistently with the guiding principles of the Data Protection Act.

2 PART 2

RESTRICTION OF PRACTICE AND EXCLUSION FROM WORK

2.1 Introduction

2.1a This part of the procedure is to be followed when restriction of practice and exclusion from work of a doctor or dentist is required.

2.1b In this part of the procedure, the phrase "exclusion from work" has been used to replace the word "suspension" which can be confused with action taken by the GMC or GDC to suspend the practitioner from the register pending a hearing of their case or as an outcome of a fitness to practice hearing.

2.1c 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 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;
- 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

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lifted.

All extensions of exclusion are reviewed and reported to the Quality and Safety Committee on a monthly basis.

2.2 Managing the risk to patients

2.2a 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.

2.2b 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") should be reserved for only the most exceptional circumstances.

2.2c The purpose of exclusion is:

- To protect the interests of patients or other staff; and/or
- To assist the investigative process when there is a clear risk that the practitioner's presence would impede the gathering of evidence.

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

2.2d Alternative ways to manage risks, avoiding exclusion, include:

- Medical or clinical lead supervision of normal contractual clinical duties;
- Restricting the practitioner to certain forms of clinical duties;
- Restricting activities to administrative, research/audit, teaching and other educational duties. By mutual agreement the latter might include some formal retraining or re-skilling;
- Sick leave for the investigation of specific health problems.

2.2e In cases relating to the capability of a practitioner, consideration will be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach will be sought from the NCAS. If the nature of the problem and a workable remedy cannot be determined in this way, the case manager will seek to agree with the practitioner to refer the case to the NCAS, which can assess the problem in more depth and give advice on any action necessary. The NCAS can offer immediate telephone advice to case managers considering restriction of practice or exclusion and, whether or not the practitioner is excluded, provide an analysis of the situation and offer advice to the case manager.
2.3 The Exclusion Process

2.3a The Trust will not exclude a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is approved. The Medical Director has the responsibility for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

Key features of exclusion from work are:

- an initial “immediate” exclusion of no more than two weeks if warranted
- notification of the NCAS before formal exclusion
- formal exclusion (if necessary for periods up to 4 weeks)
- advice on the case management plan from the NCAS
- Appointment of a designated Board member to monitor
- the exclusion and subsequent action;
- referral to NCAS for formal assessment, if part of case management plan
- active review to decide renewal or cessation of exclusion
- the right to return to work if review not carried out
- performance reporting on the management of the case through the Quality and Safety Committee
  - a right for the doctor to make representation to the designated Board member
  - programme for return to work if not referred to disciplinary procedures or performance assessment

2.4 Roles of Officers

2.4a The Medical Director has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by nominated persons. The Medical Director will discuss the case fully with the Lead Director for HR or delegated officer, the NCAS and other interested parties (such as the police where there are serious criminal allegations or the Counter Fraud & Security Management Service) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion.

The authority to exclude a member of staff is vested in the, Medical Director and Lead Director for HR or delegated officer.

2.4b The investigating officer will provide factual information to assist the case manager in reviewing the need for exclusion

2.5 Immediate exclusion

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

- 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 exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to seek further advice from the NCAS at the earliest opportunity. The Medical Director must explain why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date up to a maximum of two weeks away at which the practitioner should return to the workplace for a further meeting. The Medical Director / case manager must advise the practitioner of their rights, including rights of representation.

2.6 Formal exclusion

2.6a A formal exclusion may only take place after the Medical Director has first considered whether there is a case to answer and then considered with the individuals outlined in section 2.4.a, whether there is reasonable and proper cause to exclude. The NCAS must be consulted where formal exclusion is being considered. If a case investigator has been appointed he or she must produce a preliminary report as soon as is possible. This preliminary report is advisory to enable the Medical Director decide on the next steps as appropriate.

2.6b The report should provide sufficient information for a decision to be made as to whether:
• The allegation appears unfounded;
or • There is a misconduct issue; or
• There is a concern about the 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.

2.6c Formal exclusion of one or more clinicians must only be used where:
(a) There is a need to protect the interests of patients or other staff pending the outcome of a full investigation of:
• allegations of misconduct,
• concerns about serious dysfunctions in the operation of a clinical service,
• concerns about lack of capability or poor performance of sufficient seriousness that it is warranted to protect patients
or
(b) The presence of the practitioner in the workplace is likely to hinder the investigation.

2.6d Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.
2.6e When the practitioner is informed of the exclusion, there should, where practicable, be a witness present and the nature of the allegations or areas of concern should be conveyed to the practitioner. The practitioner should be told of the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction).

2.6f The formal exclusion must be confirmed in writing as soon as is reasonably practicable. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion and that a full investigation or what other action will follow. The practitioner and their companion should be informed that they may make representations about the exclusion to the designated Board member at any time after receipt of the letter confirming the exclusion.

2.6g In cases when disciplinary procedures are being followed, exclusion may be extended for four-week renewable periods until the completion of disciplinary procedures if a return to work is considered inappropriate. The exclusion should still only last for four weeks at a time and be subject to review. The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

2.6h If the Medical Director considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred to the NCAS for advice as to whether the case is being handled in the most effective way and suggestions as to possible ways forward. However, even during this prolonged period the principle of four-week "renewability" must be adhered to.

2.6i If at any time after the practitioner has been excluded from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Medical Director must lift the exclusion and make arrangements for the practitioner to return to work with any appropriate support as soon as practicable.

2.7 Exclusion from premises

2.7a Practitioners should not be automatically barred from the premises upon exclusion from work. The case manager must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the practitioner should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where the practitioner may be a serious potential danger to patients or other staff.

In other circumstances, however, there may be no reason to exclude the practitioner from the premises. The practitioner may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.
2.8 Keeping in contact and availability for work

2.8a Exclusion under this procedure will be on full pay, provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner must inform the Medical Director of any other organisation(s) with whom they undertake either voluntary or paid work and seek the Medical Director’s consent to continue to undertake such work or to take annual leave or study leave. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Medical Director may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

2.8b The Medical Director should make arrangements to ensure that the practitioner can keep in contact with colleagues on professional developments (where appropriate), and take part in Continuing Professional Development (CPD) and clinical audit activities with the same level of support as other doctors or dentists in their employment. A mentor could be appointed for this purpose if a colleague is willing to undertake this role.

2.9 Informing other organisations

2.9a In cases where there is concern that the practitioner may be a danger to patients, the Trust has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons for it. Details of other employers (NHS and non-NHS) may be readily available from job plans, but where it is not the practitioner should supply them. Failure to do so may result in further disciplinary action or referral to the relevant regulatory body, as the paramount interest is the safety of patients. Where a NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

2.9b Where the Medical Director believes that the 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 and the Director of Public Health or to consider requesting the issue of a Healthcare Professional Alert Notice (HPAN).

2.10 Keeping Exclusions under Review:

The Quality and Safety Committee must be informed about exclusion at the earliest opportunity.

- a summary of the progress of each case at the end of each period of exclusion will be provided to the Quality and Safety Committee, 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 has been reviewed and extended will be provided to the Quality and Safety Committee.
Attached as appendix 1 is a flow chart of the exclusion review process which must be adhered to at all times.

2.11 Return to Work

If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the practitioner. It must be clear whether clinical and other responsibilities are to remain unchanged or what the duties and restrictions are to be and any monitoring arrangements to ensure patient safety.

3 PART 3

CONDUCT AND DISCIPLINARY MATTERS

3.1 Introduction

Misconduct matters for doctors and dentists, as for all other staff groups, that involve allegations that are considered to amount to personal misconduct are dealt with under the Trust’s Disciplinary Procedure.

However, where there are any concerns about a doctor or dentist that are considered to amount to professional misconduct then this procedure will apply.

The Trust is strongly advised to contact the NCAS for advice before deciding to proceed with an investigation on the basis that it involves personal misconduct or professional misconduct.

Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional conduct proceeds to a hearing under the Trust’s Disciplinary Procedure the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.

3.2 Codes of Conduct

3.2a 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”.

3.2b Any allegation of misconduct against a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset.

3.2c It is for the Trust to decide upon the most appropriate way forward having
consulted the NCAS and/or their own employment law specialist.

3.3 Criminal Charges or convictions outside Employment

Staff who are arrested on any charge or cautioned or served with a summons for a criminal charge must inform the employer. Failure to do so may render the individual liable to disciplinary action.

No employee should be disciplined simply because of a charge or conviction and no decision should be made without an investigation.

The disciplinary procedure should not normally be deferred simply because the outcome of a prosecution is not yet known.

The length of any prison sentence, the type of offence and the needs of the Trust may be considered before a decision is made whether or not disciplinary action will be taken.

3.4 Terms of Settlement on Termination of Employment

In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated.

4 PART 4

PROCEDURE FOR DEALING WITH ISSUES OF CAPABILITY

4.1a Introduction and General Principles

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.

4.1b Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from the NCAS will help the Trust to come to a decision on whether the matter raises questions about the practitioner’s capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, the matter must be referred to the NCAS before the matter can be considered by a capability panel (unless the practitioner refuses to have his or her case referred). The Trust is strongly advised to involve the NCAS in all other cases particularly those involving professional capability.

4.1c Matters which may fall under the Trust’s capability procedures include:
4.1d Wherever possible, the Trust will aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. The NCAS has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist.

4.1e Any concerns about capability relating to a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor, with close involvement of the postgraduate dean from the outset.

4.2 How to proceed where conduct and capability issues involved

4.2a 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. Although it is for the Trust to decide upon the most appropriate way forward having consulted the NCAS and/or their own employment law specialist.

4.3 Duties of Employers

4.3a The procedures set out below and in appendix 1 are designed to cover issues where a doctor’s or dentist’s capability to practise is in question. Prior to commencing an investigation the employer will consider the scope for resolving the issue through counselling or retraining and will take advice from the NCAS.

4.3b 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. The Trust will follow its own Sickness Absence Management Policy for dealing with ill health – including obtaining advice from Occupational Health.

This is not an exhaustive list.
5  PART 5

HANDLING CONCERNS ABOUT A PRACTITIONERS HEALTH

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

5.1a The Trust’s key principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained (for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS.

5.2  Retaining the services of individuals with health problems

5.2a Wherever possible the Trust will attempt to continue to employ individuals provided this does not place patients or colleagues at risk. In particular, the Trust will consider the following actions for staff with ill-health problems:

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

This is not an exhaustive list

5.3  Reasonable adjustment

5.3a At all times the practitioner will be supported by the Trust and the Occupational Health Service (OHS) which will ensure that the practitioner is offered every available resource to get back to practise where appropriate. The Trust will consider what reasonable adjustments could be made to their workplace or other arrangements, in line with the Equality Act 2010. Some examples may include:

- Making adjustments to the premises;
- Re-allocating some of a disabled person’s duties to another;
- Transferring an employee to an existing vacancy;
- Altering an employee’s working hours or pattern of work;
- Assigning the employee to a different workplace;
- Allowing absence for rehabilitation, assessment or treatment;
- Providing additional training or retraining;
5.3b In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency advice. However, any issues relating to conduct or capability that have arisen will be resolved, using the appropriate agreed procedures.

5.4 **Handling Health Issues**

5.4a Where there is an incident that points to a problem with the practitioner’s health, the incident may need to be investigated to determine a health problem. If the report recommends Occupational Health Service involvement, the nominated manager must immediately refer the practitioner to a qualified occupational physician (usually a consultant) with the Occupational Health Service.

5.4b The NCAS should be approached to offer advice on any situation and at any point where the employer is concerned about a doctor or dentist. Even apparently simple or early concerns should be referred as these are easier to deal with before they escalate.

5.4c The occupational health physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Lead Director for HR or delegated officer, the Medical Director or case manager, the practitioner to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.

5.4d If a doctor or dentist’s ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and the professional regulatory body must be considered irrespective of whether or not they have retired on the grounds of ill health.

5.4e 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 NCAS. In these circumstances the procedures in part 4 should be followed.
5.4f There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust will refer the doctor or dentist 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.

5.4g Special Professional Panels (generally referred to as the “three wise men”) were set up by under circular HC(82)13. This part of the procedure replaces HC(82)13 which is cancelled.

6 PART 6

FORMAL PROCEDURES – GENERAL PRINCIPLES

6.1 Termination of Employment with Performance Issue Unresolved

6.1a Where an employee leaves employment before formal procedures have been completed, the investigation must be taken to a final conclusion in all cases and performance proceedings will be completed where possible and appropriate.

6.1b 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. The Trust will make a judgement, based on the evidence available, as to whether the allegations are upheld. If the allegations are upheld, the Trust will take appropriate action, such as requesting the issue of a HPAN and referral to the professional regulatory body, referral to the police, or the Protection of Children Act List (held by the Department for Education).

6.2 Handling of illness arising during formal proceedings

6.2a If an excluded employee or an employee facing formal proceedings becomes ill, they will be subject to the Trust’s Sickness Absence Management Policy. The sickness absence procedures can take place alongside formal procedures. Where the employee’s illness exceeds 4 weeks, they must be referred to the OHS. The OHS will advise the employer on the expected duration of the illness and any consequences the illness may have for the process. OHS will also be able to advise on the employee’s capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

6.2b There will be circumstances where an employee who is subject to proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist 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

6.2c If, in exceptional circumstances, a hearing proceeds in the absence of the
practitioner, for reasons of ill-health, the practitioner will have the opportunity
to submit written submissions and/or have a representative attend in his or
her absence.

6.2d 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).

7 TRAINING

There is no mandatory training associated with this policy. All individuals having a
role in this policy will have the relevant experience/expertise and/or training

8 MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trusts’ monitoring arrangements for this
policy/document. The Trust reserves the right to commission additional work or
change the monitoring arrangements to meet organisational needs.

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group / committee which will receive the findings / monitoring report</th>
<th>Group / committee / individual responsible for ensuring that the actions are completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of processes for managing Practitioners performance concerns</td>
<td>Written report</td>
<td>RO</td>
<td>Annually</td>
<td>Quality &amp; Safety Committee</td>
<td>RO</td>
</tr>
<tr>
<td>Any negative effects of this policy on employees with a protected characteristic</td>
<td>Monitoring and analysis of the equality profile of employees at each stage of the procedure</td>
<td>HR</td>
<td>Annually</td>
<td>Equality &amp; Diversity Group</td>
<td>HR</td>
</tr>
</tbody>
</table>
9 REFERENCES/ BIBLIOGRAPHY

Maintaining High Professional Standards in the Modern NHS
Equality Act 2010
National Clinical Assessment Service www.ncas.nhs.uk
The Protection of Children Act 1999 – A Practical Guide to the Act for all
Organisations Working with Children”

10 RELATED TRUST POLICY/PROCEDURES

Trust Disciplinary Policy
Trust Grievance policy
Sickness Absence Management Policy
Responding to concerns about medical and dental staff policy
APPENDIX 1  EXCLUSION REVIEW PROCESS

Regular review

- The Medical Director must review the exclusion before the end of each four week period.
- The exclusion should usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time the original reasons for exclusion no longer apply and there are no other reasons for exclusion.
- The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.
- The Trust must take review action before the end of each 4-week period
- After three exclusions, the NCAS must be called in.

The information below outlines the activities that must be undertaken at different stages of exclusion.

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

Before the end of each exclusion (of up to 4 weeks) the position must be reviewed.
- The Medical Director decides on next steps as appropriate. Further renewal may be for up to 4 weeks;
- Each renewal is a formal matter and must be documented as such;
  The practitioner must be sent written notification on each occasion

Third review

If the practitioner has been excluded for three periods:
- The case must formally be referred to the NCAS explaining why continued exclusion is appropriate and what steps are being taken to conclude the exclusion, at the earliest opportunity;
- The NCAS will review the case and advise the Trust on the handling of the case until it is concluded.

6 months review

If the exclusion has been extended over six months:
- The employer and the NCAS should actively review all cases at least every six months
APPENDIX 2  GUIDANCE ON CONDUCTING CAPABILITY HEARINGS

The Pre-Hearing Process
When an investigation report under Part 1 of the procedure has been received, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.

The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. The case manager will need to consider urgently:

- Whether action under Part 2 of the procedure is necessary to exclude the practitioner; or
- To place temporary restrictions on their clinical duties.

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

Where appropriate the NCAS will assist the Trust in drawing up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by the NCAS, but the advice of its assessment panel is that the practitioner’s performance is so fundamentally flawed that no educational and/or 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 NCAS advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

If the practitioner does not agree to the case being referred to the NCAS, a panel hearing will normally be necessary.
If a capability hearing is to be held, the following procedure will be followed beforehand:

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

- All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing;

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

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

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

- If witnesses who are required to attend the hearing choose to be accompanied, the accompanying person will not be able to participate in the hearing.

The Hearing Framework
The capability hearing will normally be chaired by an Executive Director of the Trust. The panel will comprise a total of 3 people, normally 2 members of the Trust Board, or senior staff appointed by the Board for the purpose of the hearing. At least one member of the panel must be a medical or dental practitioner who is not employed by the Trust. As far as is reasonably possible or practical, no member of the panel or advisers to the panel should have been previously involved in carrying out the investigation. Arrangements must be made for the panel to be advised by:
- A senior member of staff from Human Resources, and
- A senior clinician from the same or similar clinical specialty as the 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 doctor in question. If for any reason the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

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

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

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

**Conduct of the capability hearing**
The hearing should be conducted as follows:

- The panel and its advisers (see paragraph 4.9.1), the practitioner, his or her representative and the case manager will be present at all times during the hearing. Witnesses will be admitted only to give their evidence and answer questions and will then retire;
- The Chairman of the panel will be responsible for the proper conduct of the proceedings. The Chairman should introduce all persons present and announce which witnesses are available to attend the hearing;
- The procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:
  - The witness to confirm any written statement and give any supplementary evidence;
  - The side calling the witness can question the witness;
  - The other side can then question the witness;
  - The panel may question the witness;
  - The side which called the witness may seek to clarify any points which have arisen during questioning but may not at this point raise new evidence.
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 be allowed to leave;
- The Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.
- The practitioner and/or their representative shall present the practitioner’s case, calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave;
- The Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner’s case on which the panel requires further clarification;
- The Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case;
- The Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner’s case. Where appropriate this statement may also introduce any grounds for mitigation;
- The panel shall then retire to consider its decision.

Decisions

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

- No action required;
- Oral agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved [stays on the employee’s record for 6 months];
- Written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved [stays on the employees’ record for 1 year];
- Final written warning that there must be an improvement in clinical performance within a specified time scale with a statement of what is required and how it might be achieved [stays on the employee’s record for 1 year];
- Termination of contract.

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example,
A record of oral agreements and written warnings should be kept on the practitioner’s personnel file but should be disregarded for disciplinary purposes after the expiry of the warning.

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.

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

**Appeals in Capability Cases**

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

- A 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 practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not re hear the case in its entirety.

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**

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

The appeal panel
The panel should consist of three members. The members of appeal panel must not have had any previous direct involvement in the matters that are the subject of the appeal, 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 (see Annex A to ‘Maintaining High Professional Standards in the Modern NHS’). 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 (or dentally qualified if appropriate) who is not employed by the Trust who must also have the appropriate training for hearing an appeal. The Trust will discuss the selection of the external medical or dental member with the Chair of the Local Negotiating Committee.

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

- A consultant from the same specialty or subspecialty as the appellant, but from another NHS employer. Where the case involves a dentist this may be a consultant or an appropriate senior practitioner;
- A senior 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 doctor in question. If for any reason the senior clinician is unable to advise on the appropriate level of competence, a doctor from another NHS employer in the same grade as the practitioner in question should be asked to provide advice.

The Trust should make the arrangements for the panel and notify the appellant as soon as possible and in any event within the recommended timetable. Every effort should be made to ensure that the panel members are acceptable to the appellant. Where in rare cases agreement cannot be reached upon the constitution of the panel, the appellant’s objections should be noted carefully.
It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability hearing. The following timetable should apply in all cases:

- Appeal by written statement to be submitted to the designated appeal point (normally the Lead Director for HR or delegated officer 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.

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

**Powers of the appeal panel**

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.

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.

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**

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

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

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

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

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

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