University Hospitals of North Midlands NHS Trust

Policy No. (HR18)
Trust Policy for Maintaining High Professional Standards in the Modern NHS

Disciplinary and Management of Performance Policy and Procedure for Medical and Dental Staff

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

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Trust Contact:	**Head of Medical Staffing and Recruitment**
Executive Lead:	**Medical Director**

Version Control Schedule

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1	October 2005	
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4	February 2008	First Policy Implementation
5	December 2016	Refresh of the policy as last policy issued 2008 and following recommendations of external audit.
6	May 2018	Minor amendment removal of reference to Code of Conduct. Approved by LNC via email agreement 10th May 2018

Statement on Trust Policies to be included in all policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the "right and freedom" of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates, the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): Our 2020 Vision: Our Sustainable Future which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

Contents **Page**

1. INTRODUCTION

1.1 This policy outlines the University Hospitals of North Midlands NHS Trust (the 'Trust') processes for Maintaining High Professional Standards in the Modern NHS. It sets out the arrangements for handling concerns about doctors and dentists conduct and capability.

1.2 This policy incorporates the disciplinary and capability procedure for Medical and Dental staff. The procedure also covers issues relating to ill health as additional guidance with reference to the Trust's Sickness Absence and Attendance Procedure.

1.3 This policy and the accompanying procedure replace all previous policies and procedures (local or national) from the date of adoption by the Trust Board.

1.4 This policy and procedure should be read in conjunction with the Trust's Disciplinary Policy and Procedure (HR01) and the Attendance Management Policy and Procedure (HR14).

2. STATEMENT

2.1 This policy will ensure that the management of all concerns about doctors and dentists capability are addressed in a fair and consistent manner. This policy, together with the Trust's Disciplinary Policy and Procedure, will ensure that the management of all concerns about doctors and dentists conduct are addressed in a fair and consistent manner.

3. SCOPE

3.1 This policy and procedure applies to all medical and dental staff employed by the Trust including those who hold honorary contracts with the Trust.

3.2 For doctors and dentists in training grades concerns about capability and some conduct issues may initially be considered as training issues and the Post Graduate Dean will be informed. The Post Graduate Dean should inform the Specialty Training Committee and future employers of any issues of concern.

4. ROLES AND RESPONSIBILITIES

4.1 Responsibility of the Trust Board

It is the responsibility of the Trust Board to ensure that the Policy and Procedure is implemented through the Trust's Line Management Structure. The Trust Board needs to agree what training its staff and its members must have completed before they take part in these proceedings

4.2 Responsibility of the Human Resources Directorate

- To provide initial support to Medical Managers/Clinicians in the application of this policy and procedure in clinical cases.
- To ensure that the policy is updated in accordance with national/legislative changes.
- To ensure that managers and case investigators receive appropriate and effective training in the operation of this policy and procedure.

4.3 Responsibility of Medical Managers

- To ensure that all medical staff are made aware of this policy and procedure and their responsibilities within it.
- To take appropriate and timely actions to address matters of concern in accordance with the Framework.
- To ensure that Clinical Managers are appropriately trained to enable them to carry out their roles in accordance with this framework.

4.4 Responsibility of the Employee

- It is the employee's responsibility to be aware of this policy/procedure and to comply with its requirements.

4.5 Role of Staff Side

- It is the role of Staff Side to negotiate, raise concern and/or provide support on a member's behalf as necessary in relation to this policy.

4. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

5.1 Human Resources professionals will provide training, advice and support to those clinicians who undertake investigations and/or sit on panels in accordance with this policy and procedure.

5.2 Those staff who are required to undertake the investigations/sit on panels must have had formal equal opportunities training before undertaking such duties.

5. MONITORING AND REVIEW ARRANGEMENTS

5.1 The operation of the policy and procedure in practice will be reviewed as legislation or new guidance is introduced or at least every 3 years.

5.2 This policy and procedure may be amended to reflect any future national advice or guidance but only by agreement with the Medical LNC. Any Directions issued by the Secretary of State will be binding upon the Trust.

7. REFERENCES

7.1 National Clinical Assessment Service – website and various documentation.

7.2 Maintaining High Professions Standards in the Modern NHS national framework for information purposes.

Appendix 1

PROCEDURE

OVERVIEW

1. This document provides a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice.

2. Throughout this framework where the term "performance" is used, it should be interpreted as referring to all aspects of a practitioner's work, including conduct, health and clinical performance. Where the term "clinical performance" is used, it should be interpreted as referring only to those aspects of a practitioner's work that require the exercise of clinical judgement or skill.

3. The framework is in six sections and covers:
   - I. Action when a concern first arises
   - II. Restriction of practice and exclusion from work
   - III. Conduct hearings and disciplinary procedures
   - IV. Procedures for dealing with issues of clinical performance
   - V. Handling concerns about a practitioner's health
   - VI. Formal procedures – general principles

SECTION I. ACTION WHEN A CONCERN FIRST ARISES

1.0 INTRODUCTION

1.2 The management of performance is a continuous process to ensure both quality of service and to protect clinicians. Numerous ways 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.

1.3 Concerns about a doctor or dentist's performance can come to light in a wide variety of ways, for examples:

- concerns expressed by other staff;
- review of performance against job plans and annual appraisal;
- monitoring of data on clinical 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; or
- following the report of one or more critical clinical incidents or near misses.

1.4 All allegations, including those made by relatives of patients, or concerns raised by colleagues, must be properly investigated to establish the facts and the substance of any allegations. Unfounded or malicious allegations can cause lasting damage to a doctor's reputation and career. Where allegations raised by a fellow employee are shown to be malicious, that employee should be subject to the relevant disciplinary procedures.

2.0 SUMMARY OF KEY ACTIONS NEEDED

2.1 The key actions needed at the outset can be summarised as follows:

- clarify what has happened and the nature of the problem or concern;
- consider discussing case with NCAS on the way forward;
- consider if urgent action needs to be taken to protect the patient/s;
- consider whether restriction of practice or exclusion is required;
- if the case can be progressed by mutual agreement consider if an NCAS assessment would help;
- if a formal approach under conduct or clinical performance procedures is required, appoint a case investigator;
- consider whether further action is required under the conduct, clinical performance or health procedures.

3.0 PROTECTING THE PUBLIC

3.1 From the outset, a fundamental consideration is the continued safety of patients and the public. Whilst exclusion from the workplace may be unavoidable it should not be the sole or first approach to ensuring patient safety. Alternative ways to manage risks, avoiding exclusion, include:

- arranging supervision of normal contractual clinical duties;
- restricting the practitioner to certain forms of clinical duties;
- restricting activities to non clinical duties. By mutual agreement the latter might include some formal retraining;
- sick leave for the investigation of specific health problems.

3.2 In the vast majority of cases when action other than immediate exclusion can ensure patient

safety the clinician should always initially be dealt with using an informal approach. Only where a resolution cannot be reached informally should a formal investigation be instigated. This will often depend on an individual's agreement to the solutions offered. It is imperative that all action is carried out without any undue delay.

4.0 DEFINITION OF ROLES

4.1 The Board, through the Chief Executive, has responsibility for ensuring that these procedures are established and followed. 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 the management of individual cases.

4.2 The key individuals that may have a role in the process are summarised below:-

- Chief Executive Officer (CEO) – **all** concerns must be registered with the CEO who, should a formal investigation be required, must ensure that the following individuals are appointed;
- the "*designated Board member*" – this is a non-executive member of the Board appointed by the Chairman of the Board, to oversee the case to ensure that momentum is maintained and consider any representations from the practitioner about his or her exclusion or any representations about the investigation;
- Case Manager – this is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority;
- Case Investigator – this is the individual who will carry out the formal investigation and who is responsible for leading the investigation into any allegations or concerns, establishing the facts, and reporting the findings to the Case Manager. He / she is normally appointed by the CEO after discussion with the Medical Director and Director of HR and should, where possible, be medically qualified;
- Director of HR 's role will be to support the Chief Executive and the Medical Director.

5.0 INVOLVEMENT OF NCAS

5.1 At any stage in the handling of a case, consideration should be given to the involvement of the NCAS. The NCAS has developed a staged approach to the services it provides to Trusts and practitioners. This includes:

- immediate telephone advice, available 24 hours;
- advice, then detailed supported local case management;
- advice, then detailed NCAS performance assessment;
- support with implementation of recommendations arising from assessment.

5.2 Employers or practitioners are at liberty to make use of the services of NCAS at any point they see fit. However, where an employing body is considering exclusion or restriction from practice the NCAS must be notified, so that alternatives to exclusion can be considered. Procedures for immediate and formal exclusion are covered respectively in Sections I and II of this framework.

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

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

- clinical performance falling well short of recognised standards and clinical practice which, if repeated, would put patients seriously at risk;
- alternatively, or additionally, issues which are on-going or recurrent.

5.5 A practitioner undergoing assessment by the NCAS must co-operate with any request from the NCAS to give an undertaking not to practice in the Health Service or private sector other than their main place of 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.

5.6 Failure on the part of either the clinician or the employer to co-operate with a referral to the NCAS may be seen as evidence of a lack of willingness to resolve performance difficulties. If the practitioner chooses not to co-operate with such a referral, and an underlying health problem is not the reason, disciplinary action may be needed.

6.0 INFORMAL APPROACH

6.1 The first task of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.

6.2 The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone. Root cause analyses of individual adverse events frequently show that these are more broadly based and can be attributed to systems or organizational 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.

6.3 In cases relating primarily to the performance of a practitioner, consideration should be given to whether a local action plan to resolve the problem can be agreed with the practitioner. The NCAS can advise on the practicality of this approach. This may involve a performance assessment by the NCAS if considered appropriate – (Section IV paragraph 7 refers). If a workable remedy cannot be determined in this way, the Medical Director, in consultation with the clinical manager, should seek the agreement of the practitioner to refer the case to the NCAS for consideration of a detailed performance assessment.

7.0 IMMEDIATE EXCLUSION

7.1 When significant issues relating to performance are identified which may affect patient safety, the employer must urgently consider whether it is necessary to place temporary restrictions on an individual's practice. Examples of such restrictions might be to amend or restrict the practitioner's clinical duties, obtain relevant undertakings e.g. regarding practice elsewhere or provide for the temporary exclusion of the practitioner from the workplace.

7.2 An immediate time limited exclusion may be necessary

- to protect the interests of patients or other staff;
- where there has been a breakdown in relationships within a team which has the potential to significantly endanger patient care.

7.3 The NCAS must, where possible, be informed prior to the implementation of an immediate exclusion. Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis and to convene a case conference involving the clinical manager, the Medical Director and appropriate representation from Human Resources.

7.4 The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. These should include, where possible, the CEO, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CEO and Medical Director. The number of managers involved should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. The clinical manager seeking an immediate exclusion must explain to the nominated manager why the exclusion is justified.

7.5 The clinical manager having obtained the authority to exclude must explain to the practitioner why the exclusion is justified (there may be no formal allegation at this stage), and agree a date up to a maximum of four weeks at which the practitioner should return to the workplace for a further meeting

7.6 Immediate exclusion should be limited to the shortest feasible time and in no case longer than 4 weeks. During this period the practitioner should be given the opportunity to state their case and propose alternatives to exclusion e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction. The clinical manager must advise the practitioner of their rights, including rights of representation.

7.7 All these discussions should be minuted, recorded and documented, and a copy given to the practitioner.

7.8 The 4 week exclusion period should allow sufficient time for initial investigation to determine a clear course of action, including the need for formal exclusion.

7.9 At any point in the process where the Medical Director has reached a judgment that a practitioner is to be the subject of an exclusion, the regulatory body may be notified. Consideration should also be given to whether the issue of a Health Professional Alert Notice (HPAN) should be requested. The process to be followed in respect of issuing HPAN is through NCAS.

7.10 Section II of this framework sets out the procedures to be followed should a formal investigation indicate that a longer period of formal exclusion is required.

8.0 FORMAL APPROACH

8.1 Where it is decided that a formal approach needs to be followed (perhaps leading to conduct or clinical performance proceedings) the CEO must, after discussion between the Medical Director and Director of HR, appoint a Case Manager, a Case Investigator and a designated Board member as outlined in paragraph 8. The seniority of the Case Investigator will differ depending on the grade of practitioner involved in the allegation.

8.2 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.

8.3 At any stage of this process - or subsequent disciplinary action - the practitioner may be

accompanied to any interview or hearing by a companion. The companion may be another employee of the Trust; an official or lay representative of the BMA, BDA, defence organisation, or friend, work or professional colleague, partner or spouse. The companion may be legally qualified but he or she will not, however, be acting in a legal capacity.

9.0 CASE INVESTIGATOR ROLE

9.1 The Case Investigator:

- must formally, on the advice of the Medical Director, involve a senior member of the medical or dental staff with relevant clinical experience in cases 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. Patient confidentiality needs to be maintained. 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;
- must ensure that sufficient written statements are collected to establish the facts of the case, and on aspects of the case not covered by a written statement, ensure that there is an appropriate mechanism for oral evidence to be considered where relevant;
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Medical Director with advice from the Director of HR;
- must assist the designated Board member in reviewing the progress of the case.

9.2 The Case Investigator does not make the decision on what action should or should not be taken, nor whether the employee should be excluded from work. They may not be a member of any disciplinary or appeal panel relating to the case.

9.3 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. Information gathered in the course of an investigation may clearly exonerate the practitioner, or provide a sound basis for effective resolution of the matter.

10.0 THE CASE MANAGER'S ROLE

10.1 The Case Manager is the individual who will lead the formal investigation. The Medical Director will normally act as the case manager but he/she may delegate this role to a senior medically qualified manager in appropriate cases. If the Medical Director is the subject of the investigation the Case Manager should be a medically qualified manager of at least equivalent seniority

10.2 The practitioner concerned must be informed in writing by the Case Manager, that an investigation is to be undertaken, the name of the Case Investigator and the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people whom the Case Investigator will interview. 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.

10.3 If during the course of the investigation, it transpires that the case involves more complex clinical issues (which cannot be addressed in the Trust), the Case Manager should consider whether an independent practitioner from another Health Service Organisation or elsewhere be invited to assist.

11.0 TIME SCALE AND DECISION

11.1 The Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days. 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.

11.2 The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- 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, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

12.0 CONFIDENTIALITY

12.1 Employers must maintain confidentiality at all times, and should be familiar with the guiding principles of Data Protection. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.

12.2 Personal data released to the Case Investigator for the purposes of the investigation must be fit for the purpose, and not disproportionate to the seriousness of the matter.

SECTION II. RESTRICTION OF PRACTICE & EXCLUSION FROM WORK

1.0 INTRODUCTION

1.1 In this part of the framework, 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.

1.2 The Directions require the Trust must ensure that:

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

2.0 MANAGING THE RISK TO PATIENTS

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

2.2 The purpose of exclusion is:

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

2.3 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 patients, the practitioner concerned and/or their colleagues.

3.0 THE EXCLUSION PROCESS

3.1 Under the Directions, the Trust cannot require the exclusion of a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four-week period of exclusion is imposed. Under the framework key officers and the Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged.

3.2 Key aspects of exclusion from work include:

- an initial "immediate" exclusion of no more than four weeks if warranted as set out in Section I;
- notification of the NCAS before immediate and formal exclusion;
- formal exclusion (if necessary) for periods up to four weeks;
- on-going 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 by clinical and case managers to decide renewal or cessation of exclusion;
- a right to return to work if review not carried out;
- performance reporting on the management of the case;
- programme for return to work if not referred to disciplinary procedures or clinical

performance assessment;
- a right for the doctor to make representation to the designated Board member

3.3 The authority to exclude a member of staff must be vested in a nominated manager or managers of the Trust. As described for immediate exclusion, these managers should be at an appropriately senior level in the organisation and should be the minimum number of people consistent with the size of the organisation and the need to ensure 24 hour availability of a nominated manager in the event of a critical incident. It should include the CEO, Medical Director and the Clinical Directors for staff below the grade of consultant. For consultants it should include the CEO and Medical Director.

3.4 **Exclusion other than immediate exclusion**.

3.4.1 A formal exclusion may only take place in the setting of a formal investigation after the Case Manager has first considered whether there is a case to answer and then considered, at a case conference (involving as a minimum the clinical manager, Case Manager and Director of HR), 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 to be available for the case conference. This preliminary report is advisory to enable the Case Manager to decide on the next steps as appropriate.

3.4.2 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 clinical performance; or
- the complexity of the case warrants further detailed investigation before advice can be given.

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

- there is a need to protect the safety of patients or other staff pending the outcome of a full investigation of:
- allegations of misconduct;
- concerns around the functioning of a clinical team which are likely to adversely affect patients;
- concerns about poor clinical performance; or
- the presence of the practitioner in the workplace is likely to hinder the investigation.

3.4.4 Members of the case conference should consider whether the practitioner could continue in or (where there has been an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

3.4.5 When the practitioner is informed of the exclusion, there should, where practical, be a witness present and the nature of the allegations of concern should be conveyed to the practitioner. The practitioner should be told the reason(s) why formal exclusion is regarded as the only way to deal with the case. At this stage the practitioner should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAS with voluntary restriction). The practitioner may be accompanied to any interview or hearing by a companion. All discussions should be minuted, recorded and documented and a copy given to the practitioner.

3.4.6 The formal exclusion must be confirmed in writing immediately. The letter should state the effective date and time, duration (up to 4 weeks), the content of the allegations, the terms of the exclusion (e.g. exclusion from the premises, see paragraph 3.5, and the need to remain available for work paragraph 3.6) 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.

3.4.7 In cases when disciplinary procedures are being followed, exclusion may be extended for four-week reviewable 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 (see paras 26 – 31 relating to the review process). 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.

3.4.8 If the Case Manager considers that the exclusion will need to be extended over a prolonged period outside of his or her control (for example because of a police investigation), the case must be referred back to the NCAS for advice as to whether the case is being handled in the most effective way. However, even during this prolonged period the principle of four-week review must be adhered to.

3.4.9 If at any time after the practitioner has been excluded from work, the investigation reveals that either the allegations are without foundation or that further investigation can continue with the practitioner working normally or with restrictions, the Case Manager must lift the exclusion and notify the appropriate regulatory authorities. Arrangements should be in place for the practitioner to return to work with any appropriate support (including retraining after prolonged exclusion) as soon as practicable.

3.5 **Exclusion from premises.** Practitioners should not be automatically barred from the premises upon exclusion from work. Case Managers must always consider whether a bar is absolutely necessary. The practitioner may want to retain contact with colleagues, take part in clinical audit, to remain up to date with developments in their specialty or to undertake research or training. There are certain circumstances, however, where the practitioner should be excluded from the premises. There may be a danger of tampering with evidence, or where the practitioner may present a serious potential danger to patients or other staff.

3.6 **Keeping in contact and availability for work.** Exclusion under this framework should be on full pay provided the practitioner remains available for work with their employer during their normal contracted hours. The practitioner should not undertake any work for other organisations, whether paid or voluntary, during the time for which they are being paid by the Trust. This caveat does not refer to time for which they are not being paid by the Trust. The practitioner may not engage in any medical or dental duties consistent within the terms of the exclusion. In case of doubt the advice of the Case Manager should be sought. The practitioner should be reminded of these contractual obligations but would be given 24 hours notice to return to work. In exceptional circumstances the Case Manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. abroad without agreement).

3.7 The Case Manager should make arrangements to ensure that the practitioner may keep in contact with colleagues on professional developments, take part in 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. In appropriate circumstances Trusts should offer practitioners a referral to the Occupational Health Service.

3.8 **Informing other organisations**. Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform other organisations including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons. Details of other employers 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 Trust has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer.

3.9 Where the Case Manager has good grounds to believe 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, they should contact the professional regulatory body and consider the issue of an alert letter.

3.10 No Practitioner should be excluded from work other than through this procedure. Informal exclusions, so called 'gardening leave' have commonly used in the past. **No Trust must use 'gardening leave' as a means of resolving a problem covered by this framework.**

3.11 **Existing suspensions & transitional arrangements**. On implementation of this framework, all informal exclusions (e.g. 'gardening leave') must be transferred to the new system of exclusion and dealt with under the arrangements set out in this framework.

3.12 **Keeping exclusions under review**

3.12.1 **Informing the board.** The Board must be informed about an exclusion at the earliest opportunity. The Board has a responsibility to ensure that the organisation's internal procedures are being followed.

3.12.2 **Regular review.** The Case Manager 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 their employment, at any time providing the original reasons for exclusion no longer apply. 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.

3.12.3 The Trust must review action before the end of each 4-week period. The Table (Table 1)below outlines the carious activities that must be undertaken at different stages of exclusion.

3.12.4 Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the practitioner concerned. The employer and the NCAS should actively review those cases at least every six months.

Table 1

Stage	Activity
First and second reviews (and reviews after the third review)	Before the end of each exclusion (of up to 4 weeks) the Case Manager reviews the position. • The Case Manager decides on the next steps as appropriate. Further renewal may be for up to 4 weeks at a time. • Case Manager submits advisory report of outcome to CEO and Medical Director. • Each review is a formal matter and must be documented as such. • The practitioner must be sent written notification of the outcome of the review on each occasion.

Third review	If the practitioner has been excluded for three periods: • A report must be made by the Medical Director to the CEO o outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; o and if the investigation has not been completed a timetable for completion of the investigation. • The case must be formally referred back to the NCAS explaining: o why continued exclusion is thought to be appropriate; o what steps are being taken to complete the investigation 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 month review	If the exclusion has been extended over 6 months, • A further position report must be made to the indicating: o the reason for continuing the exclusion; o anticipated time scale for completing the process; o actual and anticipated costs of the exclusion.

3.13 **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, what duties and restrictions apply, and any monitoring arrangements to ensure patient safety.

SECTION III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES

1.0 INTRODUCTION

1.1 This section applies when the outcome of an investigation under Section I shows that there is a case of misconduct that must be put to a conduct panel. Misconduct covers both personal and professional misconduct as it can be difficult to distinguish between them. The key point is that all misconduct issues for doctors and dentists (as for all other staff groups) are matters for local employers and must be resolved locally. All misconduct issues should be dealt with under the Trust Disciplinary Policy HR01.

1.2 It should be noted that if a case covers both misconduct and clinical performance issues it should usually be addressed through a clinical performance procedure (Section IV refers).

1.3 Where the investigation identifies issues of professional misconduct, the Case Investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional misconduct 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.

1.4 Advice from NCAS in misconduct cases to be obtained, particularly in cases of professional misconduct.

1.5 The Trust must develop strong co-partnership relations with universities and ensure that jointly agreed procedures are in place for dealing with any concerns about practitioners with joint appointment contracts (reference Appendix 2).

2.0 Codes of Conduct

2.1 The Job descriptions for staff, set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these standards are considered to be "misconduct". Misconduct can cover a very wide range of behaviour and can be classified in a number of ways, but it will generally fall into one of four distinct categories:

- a refusal to comply with the requirements of the Trust where these are shown to be reasonable;
- an infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required of doctors and dentists by their regulatory body;
- the commission of criminal offences outside the place of work which may, in particular circumstances, amount to misconduct;
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

3.0 Examples of Misconduct

3.1 The Trusts Disciplinary Policy HR01 sets out details of some of the acts that will result in a serious breach of contractual terms and will constitute gross

misconduct, and could lead to summary dismissal. The code cannot cover every eventuality. Acts of misconduct may be simple and readily recognised or more complex and involved. Examples may include unreasonable or inappropriate behaviour such as verbal or physical bullying, harassment and/or discrimination in the exercise of their duties towards patients, the public or other employees. It could also include actions such as deliberate falsification or fraud.

3.2 Failure to fulfil contractual obligations may also constitute misconduct. For example, regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities may come into this category. Additionally, instances of failing to give proper support to other members of staff including doctors or dentists in training may be considered in this category.

3.3 It is for the employer to decide upon the most appropriate way forward, including the need to consult the NCAS and their own sources of expertise on employment law. If a practitioner considers that the case has been wrongly classified as misconduct, he or she (or his/her representative) is entitled to use the employer's grievance procedure. Alternatively, or in addition, he or she may make representations to the designated Board member.

3.4 In all cases where an allegation of misconduct has been upheld consideration must be given to referral to GMC/GDC.

4.0 Allegations of Criminal Acts

4.1 **Action when investigations identify possible criminal acts.** Where an employer's investigation establishes a suspected criminal action in the UK or abroad, this must be reported to the police. The Trust investigation should only proceed in respect of those aspects of the case that are not directly related to the police investigation underway. The employer must consult the police to establish whether an investigation into any other matters would impede their investigation. In cases of fraud, the Counter Fraud and Security Management Service must be contacted.

4.2 **Cases where criminal charges are brought not connected with an investigation by the Trust.** There are some criminal offences that, if proven, could render a doctor or dentist unsuitable for employment. In all cases, employers, having considered the facts, will need to determine whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The Trust will have to give serious consideration to whether the employee can continue in their current duties once criminal charges have been made. Bearing in mind the presumption of innocence, the employer must consider whether the offence, if proven, is one that makes the doctor or dentist unsuitable for their type of work and whether, pending the trial, the employee can continue in their present duties, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser.

4.3 **Dropping of charges or no court conviction**. If the practitioner is acquitted following legal proceedings, but the employer feels there is enough evidence to suggest a potential danger to patients, the Trust has a public duty to take action to ensure that the practitioner does not pose a risk to patient safety. Where the charges are dropped or the court case is withdrawn, there may be grounds to

consider allegations which if proved would constitute misconduct, bearing in mind that the evidence has not been tested in court. It must be made clear to the police that any evidence they provide and is used in the Trust's case will have to be made available to the doctor or dentist concerned.

SECTION IV. PROCEDURES FOR DEALING WITH ISSUES OF CLINICAL PERFORMANCE

1.0 INTRODUCTION & GENERAL PRINCIPLES

1.0 There will be occasions following an adequate investigation where the Trust considers that there has been a clear failure by an individual to deliver an acceptable standard of care, or standard of clinical management, through lack of knowledge, ability or consistently poor performance. These are described as clinical performance issues.

1.1 Concerns about the clinical performance of a doctor or dentist may arise as outlined in Section I. Advice from the NCAS will help the Trust to come to a decision on whether the matter raises questions about the practitioner's performance as an individual (health problems, conduct difficulties or poor clinical performance) or whether there are other matters that need to be addressed. If the concerns about clinical performance cannot be resolved through local informal processes set out in Section I **the matter must be referred to the NCAS before consideration by a performance panel** (unless the practitioner refuses to have his or her case referred).

1.2 Matters which may fall under the performance procedures include:

- out moded clinical practice;
- inappropriate clinical practice arising from a lack of knowledge or skills that puts patients at risk;
- incompetent clinical practice;
- inappropriate delegation of clinical responsibility;
- inadequate supervision of delegated clinical tasks;
- ineffective clinical team working skills.

Wherever possible such issues should be dealt with informally, seeking support and advice from the NCAS where appropriate. The vast majority of cases should be adequately dealt with through a plan of action agreed between the practitioner and the Trust

1.4 Performance may be affected by ill health. Should health considerations be the predominant underlying feature, procedures for handling concerns about a practitioner's health are described in Section V of this framework.

2.0 How to proceed where conduct and clinical performance issues are involved

2.1 It is inevitable that some cases will involve both conduct and clinical performance issues. Such cases can be complex and difficult to manage. If a case covers more than one category of problem, it should usually be addressed through a clinical performance hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the Trust to decide on the most appropriate way forward having consulted with an NCAS adviser and expert on employment law.

2.2 The procedures set out below are designed to cover issues where a doctor's or dentist's standard of clinical performance is in question.

2.3 As set out in Section I, the NCAS can assist the Trust to draw up an action plan

designed to enable the practitioner to remedy any limitations in performance that have been identified during the assessment. The Trust must facilitate the agreed action plan (agreed by the Trust and the practitioner). There may be occasions when a case has been considered by 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 clinical performance procedure. If so, a panel hearing will be necessary.

2.4 If the practitioner does not agree to the case being referred to NCAS, a panel hearing will normally be necessary.

3.0 Hearing Procedure

3.1 **The pre-hearing process.** The following procedure should be followed before the hearing:

- the Case Manager must notify the practitioner in writing of the decision to arrange a clinical performance 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 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 wish;

- 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 Trust can consider whether a new date should be set for the hearing.

- should either party request a postponement to the hearing, the Case Manager should give reasonable consideration to such a request while ensuring that any time extensions to the process are kept to a minimum. The Trust retain the right, after a reasonable period (not normally less than 30 working days from the postponement of the hearing), and having given the practitioner at least five working days' notice, to proceed with the hearing in the practitioner's absence, although the Trust should act reasonably in deciding to do so;

- should the practitioner's ill health prevent the hearing taking place, the Trust should implement the 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 clinical performance hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman of the panel should invite the witness to attend. The Chairman cannot require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel

should reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two working days in advance of the hearing.

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

3.2 **The hearing framework**. The hearing will normally be chaired by an Executive Director of the Trust. The panel should 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 an appropriately experienced medical or dental practitioner who is not employed by the Trust. No member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

3.3 Arrangements must be made for the panel to be advised by:

- A senior member of staff from Human Resources;
- An appropriately experienced clinician from the same or similar clinical speciality as the practitioner concerned, but from another Trust:
- A representative of a university if provided for in any protocol agreed between the employer and the university.

3.4 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 selected 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. In the case of doctors in training the postgraduate dean's advice should be sought.

3.5 It is for the employer to decide on the membership of the panel. A practitioner may raise an objection to the choice of any panel member within 5 working days of notification. The employer should 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 employer must provide the practitioner with the reasons for reaching its decision in writing before the hearing can take place.

3.6 **Representation at clinical performance hearings**

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

3.8 The practitioner may be represented in the process by a companion who may be another employee of the Trust: an official or lay representative of the BMA, BDA, defence organisation or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

3.7 **Conduct of the clinical performance hearing.** The hearing should be conducted as follows:

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

- 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.

3.8 The order of presentation shall be:

- the Case Manager presents the management case, calling any witnesses. The procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;

- 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 procedure set out above for dealing with witnesses shall be followed for each witness in turn. Each witness shall be allowed to leave when the procedure is completed;

- 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.

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

- a finding that the allegations are unfounded and practitioner exonerated. Finding placed on the practitioner's record;

- a finding of unsatisfactory clinical performance. All such findings require a written statement detailing:
    - the clinical performance problem(s) identified;
    - the improvement that is required;
    - the timescale for achieving this improvement;
    - a review date;
    - measures of support the employer will provide; and
    - the consequences of the practitioner not meeting these requirements.

3.10 In addition, dependent on the extent or severity of the problem, the panel may:

- issue a written warning or final written warning that there must be an improvement in clinical performance within a specified time scale together with the duration that these warnings will be considered for disciplinary purposes (up to a maximum of two years depending on severity);

- decide on termination of contract.

3.11 In all cases where there is a finding of unsatisfactory clinical performance, consideration must be given to referral to the GMC/GDC.

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. The panel may wish to comment on the systems and procedures operated by the employer.

3.12 A record of all findings, decisions and written warnings should be kept on the practitioner's personnel file. Written warnings should be disregarded for disciplinary purposes following the specified period.

3.13 The decision of the panel should be communicated verbally to the parties as soon as possible and normally within 5 working days of the hearing. Given the possible 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.

3.14 The decision must be confirmed in writing to the practitioner within 10 working days. This notification must include reasons for the decision, clarification of the practitioner's right of appeal (specifying to whom the appeal should be addressed) and notification of any intent to make a referral to the GMC/GDC or any other external/professional body.

4.0 Appeals Procedures in Clinical Performance Cases

4.1 Given the significance of the decision of a clinical performance panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place.

4.2 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.

4.3 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 entire case but may direct that the case is re-heard if it considers it appropriate.

4.4 **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 clinical performance 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 clinical performance hearing.

4.5 Where the appeal is against dismissal, the practitioner should not be paid, from the date of termination of employment. Should the appeal be upheld, the practitioner should be reinstated and must be paid backdated to the date of termination of employment. Where the decision is to re-hear 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.

4.6 **The appeal panel**. The panel should 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:

Membership of the appeal panel

- an independent member (trained in legal aspects of appeals) from an approved pool. 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.

In the case of clinical academics, including joint appointments, a further panel member may be appointed in accordance with any protocol agreed between the employer and the university

4.7 The panel should call on others to provide specialist advice. This should

normally include:

- a consultant from the same specialty or subspecialty as the appellant, but from another Trust:
- a senior Human Resources specialist.

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 selected 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. Where the case involves a doctor in training, the postgraduate dean should be consulted.

4.8 The Trust should convene the panel and notify the appellant as soon as possible. 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. The Trust needs to act reasonably at all stages of the process.

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

- appeal by written statement to be submitted to the designated appeal point (normally the Director of HR) 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.

4.10 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.

4.11 **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.

4.12 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.

4.13 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 re-heard, on the basis of the new evidence, by a clinical performance hearing panel.

4.14 **Conduct of appeal hearing.** All parties should have all documents, including witness statements, from the previous performance hearing together with any new evidence.

4.15 The practitioner may be represented in the process by a companion who may be another employee of the Trust; an official or lay representative of the BMA, BDA, defence organisation, or work or professional colleague. Such a representative may be legally qualified but they will not, however, be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any written evidence.

4.16 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.

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

4.18 **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.

4.19 **Action following hearing.** Records must be kept, including a report detailing the performance 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 clinical performance procedure and Data Protection. 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 Industrial Tribunal.

SECTION V. HANDLING CONCERNS ABOUT PERFORMANCE ARISING FROM A PRACTITIONER'S HEALTH

1.0 INTRODUCTION

1.1 This section applies when the outcome of an investigation under Section I shows that there are concerns about the practitioner's health that should be considered by the Trust's Occupational Health Service (OHS).

1.2 In addition, if at any stage in the context of concerns about a practitioner's clinical performance or conduct it becomes apparent that ill health may be a factor, the practitioner should be referred to OHS. The practitioner may also self refer to OHS.

1.3 The principle for dealing with individuals with health problems is that, wherever possible and consistent with maintaining patient safety, 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 health service.

3.0 HANDLING HEALTH ISSUES

3.1 On referral to OHS, the OHS physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director of HR, the Medical Director or Case Manager, the practitioner and case worker from the OHS to agree a timetable of action and rehabilitation (where appropriate). The practitioner may be accompanied to these meetings (as defined in Section I). Confidentiality must be maintained by all parties at all times.

3.2 The findings of OHS may suggest that the practitioner's health makes them a danger to patients. Where the practitioner does not recognise that, or does not comply with measures put in place to protect patients, then exclusion from work must be considered. The relevant professional regulatory body must be informed, irrespective of whether or not the practitioner has retired on the grounds of ill health.

3.3 In those cases where there is impairment of clinical performance solely due to ill health or an issue of conduct solely due to ill health, disciplinary procedures (as outlined in Section IV), or misconduct procedures (as outlined in Section III) would only be considered 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 refusing a referral to the OHS or NCAS.

3.4 A practitioner who is subject to the procedures in Sections III and IV may put forward a case on ill health grounds that proceedings should be delayed, modified or terminated. In those cases the employer should refer the practitioner to OHS for assessment as soon as possible and suspend proceedings pending the OHS report. Unreasonable refusal to accept a referral to, or to co-operate with OHS, may give separate grounds for pursuing disciplinary action.

3.0 RETAINING THE SERVICES OF INDIVIDUALS WITH HEALTH PROBLEMS

3.1 Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk. The following are examples of actions a Trust might take in these circumstances, in consultation with OHS and having taken advice from NCAS.

Examples of action to take

- 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;
- make adjustments to the practitioner's working environment;
- reassign them to a different area of work;
- arrange re-training for the practitioner;
- consider whether the Disability Discrimination Act (DDA) applies (see below), and, if so, what other reasonable adjustments might be made to their working environment.

4.0 DISABILITY DISCRIMINATION ACT (DDA)

4.1 Where the practitioner's health issues come within the remit of the DDA, the employer is under a duty to consider what reasonable adjustments can be made to enable the practitioner to continue in employment. At all times the practitioner should be supported by their employer and OHS who should ensure that the practitioner is offered every available resource to enable him/her to continue in practice or return to practice as appropriate.

4.2 Employers should consider what reasonable adjustments could be made to the practitioner's workplace conditions, bearing in mind their need to negate any possible disadvantage a practitioner might have compared to his/her non-disabled colleagues. The following are examples of reasonable adjustments an employer might make in consultation with the practitioner and OHS.

Examples of reasonable adjustment

- make adjustments to the premises;
- re-allocate some of the disabled person's duties to another;
- transfer employee to an existing vacancy;
- alter employee's working hours or pattern of work;
- assign employee to a different workplace;
- allow absence for rehabilitation, assessment or treatment;
- provide additional training or retraining;
- acquire/modify equipment;
- modifying procedures for testing or assessment;
- provide a reader or interpreter;
- establish mentoring arrangements.

4.3 In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in consultation with the practitioner, OHS, and NHS Pensions Agency**.**

SECTION VI RESTORING DOCTORS AND DENTISTS TO SAFE PROFESSIONAL PRACTICE – RETURN TO WORK

1.0 Introduction

1.1 This procedure provides a framework for helping doctors to return to safe practice following local or national performance procedures

1.2 The Trust recognises the importance of having a structured approach to restoring a practitioner back to safe practice and ensuring a managed and effective return to work following a significant period of absence. Its key focus is on practitioners about whose practice concerns have been raised. The practitioner may, as a result, have been excluded form work, or subject to disciplinary action and/or performance assessment. Several external bodies may have been involved, e.g. the GMC, NCAS, the Royal College or Faculty.

2.0 Safety of Patients

2.1 Whilst it is recognised that an appropriate balance needs to be achieved with regard to patient safety, support for the practitioner, and the interest of Trust, wherever a conflict of interest is identified, the needs of individual patients are paramount. This can be achieved through structured return to work programmes operating within a robust clinical governance framework.

2.2 Practitioners are not expected to resume practice until appropriate steps have been taken to address any re-skilling requirements and the clinical area to which they will return has been adequately prepared for their return. The aim is to make the transition back to work as smooth and efficient as possible, in a way that is safe and effective for patients, colleagues and the practitioner.

4.0 Responsibility of the Practitioner and the Trust

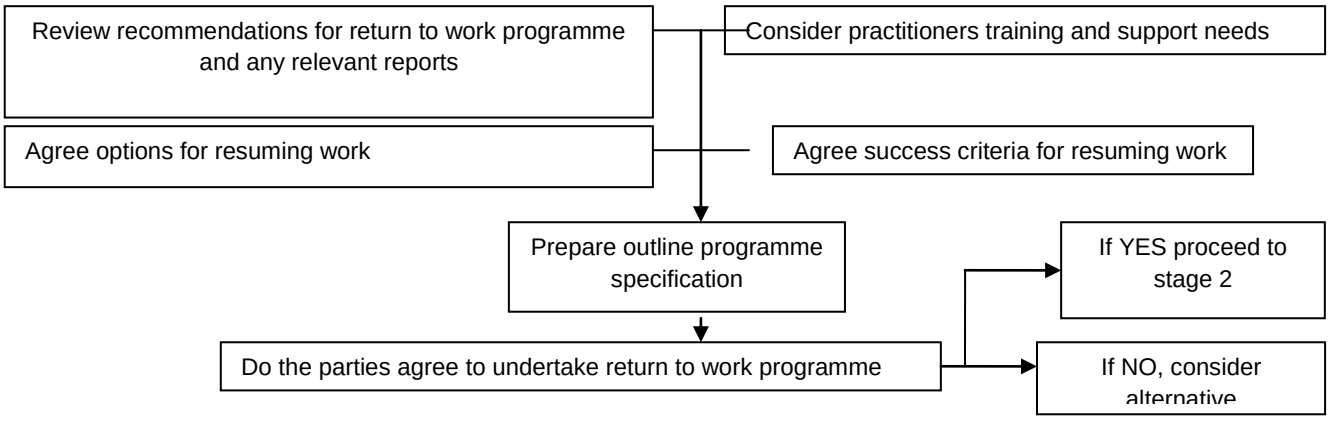
3.1 The success of the programme is the responsibility of everyone associated with it. The Trust's commitment to supporting a practitioner undertaking a return to work programme must be matched by the commitment of the practitioner to take all reasonable steps to maximise the potential of a successful outcome.

3.2 Senior Managers will ensure stakeholders need to be clear about their individual responsibilities in supporting the process.

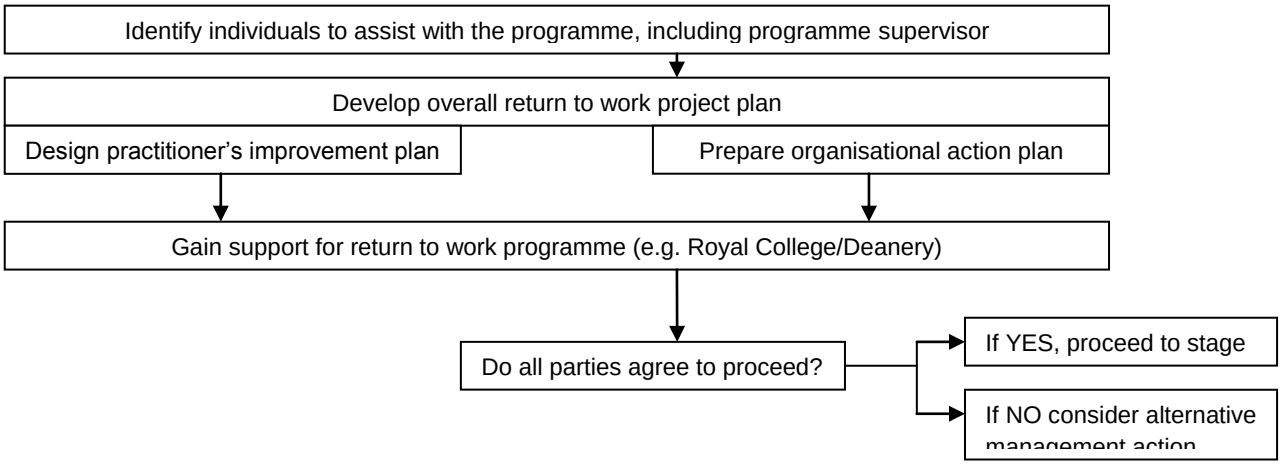
4.0 Management of the Process

4.1 There are 4 key stages to any return to work programme and these are set out in the attached flow chart. Each stage has a clear starting point and a decision point at its conclusion. If performance through any stage is not acceptable, the individual with overall responsibility for managing the programme will need to decide on necessary actions before the practitioner may progress to the next stage.

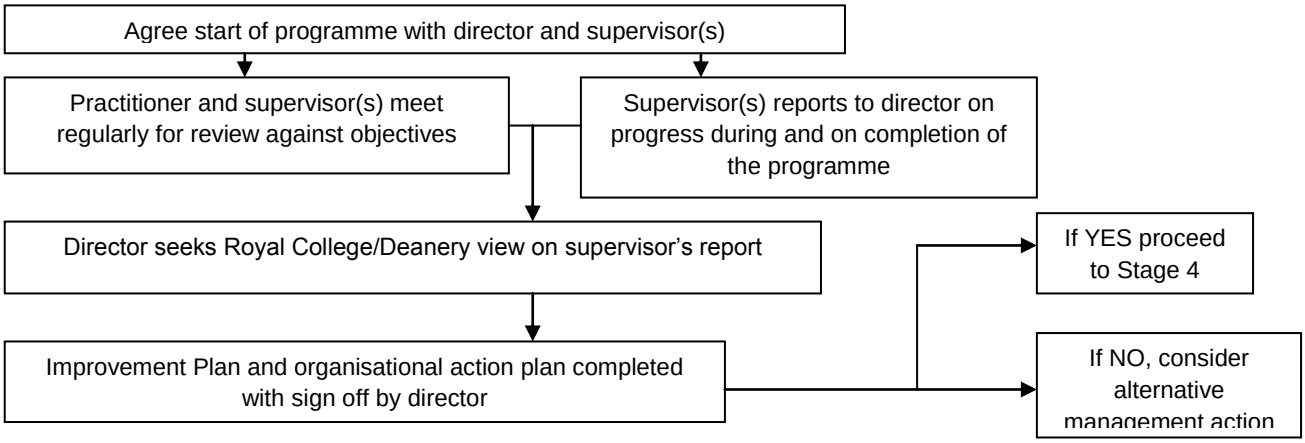
Stage 1 Entry to return to work programme



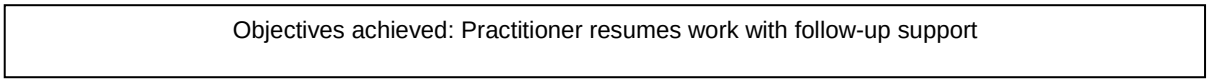
Stage 2 – Devise and agree return to work programme



Stage 3 – Implement plan and review progress



Stage 4 – Complete programme and arrange follow up



5.0 **Roles and Responsibilities**

5.1 Practitioner. The practitioner will need to cooperate with any investigation, review and/or assessment by the Trust, Deanery, Royal College, NCAS or GMC and act on the findings, conclusions and recommendations. She/he will need to be proactive in seeking help to address concerns raised and developing and implementing an improvement plan, with a commitment to an on-going programme of continuing professional development after successful completion of the improvement plan.

5.2 Trust. The Trust Medical Director or Responsible Officer will act as the responsible Director and will manage an individual case (in accordance with the processes identified in earlier sections of this policy), or in the case of Medical Staff other than consultants, the responsibility will be delegated to an Associate Medical Director.

5.3 The responsible Director will plan and oversee arrangements and work with a practitioner, in conjunction with a programme supervisor, to design and implement an improvement plan following investigation, review or assessment.

5.4 The responsible Director will receive reports from the programme supervisor, and will make a decision about the practitioner's future role and employment status.

5.5 The responsible Director will agree funding arrangements for the programme and will arrange for any organisational issues that relate to the case to be addressed.

5.6 The Trust will need to take action, where progress during a return to work programme is not satisfactory.

5.7 Other Professional Bodies

5.8 For doctors appointed to a Deanery approved training programme, the Deanery will be involved in planning targeted training following local performance procedures, RITA panel outcomes, NCAS or GMC assessments where appropriate. They will be expected to identify an alternative training placement to meet the needs of the trainee. This will include identifying a named clinical and programme supervisor and agreeing arrangements for monitoring performance against objectives. In addition, they will advise on provision of mentoring and coaching when required and provide access to confidential psychological support.

5.9 For doctors who are not appointed to, or substantively employed in, Deanery approved training programmes, (or who are unemployed) the Deanery may see practitioners referred by the NCAS or GMC who live or work in the area. The purpose will be to help the referred doctor to develop an improvement plan to address identified weaknesses in performance and agree a means and timescale for monitoring progress against objectives. In addition they may organise, where appropriate and practicable, an unpaid clinical attachment with a consultant who will be asked to provide written feedback.

5.10 The NCAS will work with the practitioner, Trust and Deanery or Royal College to agree an improvement plan and/or organisational action plan to implement the recommendations made in a NCAS report.

5.11 Most Medical Royal Colleges and their faculties will provide advice and support to the Trust in handling cases where concerns arise relating to the

performance of practitioners. This includes help with access to retraining programmes. They may, where necessary, assist in finding suitable placements and advise on the level of supervision and the assessment process.

6.0 Funding

6.1 It is likely that a contribution to funding a rehabilitation programme will be required from the practitioner in addition to the Trust. This is of course dependent upon the nature and duration of the return to work programme. Clarity about funding arrangements will be discussed between all parties at the outset of the improvement plan.

7.0 Indemnity

7.1 Clear arrangements will be required to cover indemnity for the practitioner's actions during their return to work programme, and those of the staff supporting and supervising them. While the usual governance arrangements for doctors in training should apply, the Trust as provider of a placement should consider whether additional indemnity is required. The NHS Indemnity Scheme (CNST) covers claims by patients or their relatives arising from alleged clinical negligence by NHS staff.

8.0 Locums and Practitioners on Short Term Contracts

8.1 NHS Professionals is intending to facilitate the whole return to work process for locum doctors working in hospital or community care by;

a) Providing an educational advisor to assist the doctor during retraining;
b) Helping identify future employment placements for retrained locum doctors;
c) Helping place these doctors into substantive posts.

8.2 The Trust may refer the locum practitioner to NHS Professionals who will then act as the temporary employer and negotiate with the Trust to allow assessment and retraining to take place.

9.0 Employment Issues

9.1 Any proposed changes to the practitioner's original contract of employment should be fully discussed with the practitioner in advance of the proposed return to work. Any agreed variations to the contract should be confirmed in writing. Any dispute arising from changes to the contract should be addressed through the Trust's Grievance Policy.

PROTOCOL BETWEEN KEELE UNIVERSITY AND UNIVERSITY HOSPITALs OF NORTH MIDLANDS (NHS) TRUST

1. The following general principles and procedure are the result of agreement between Keele University and University Hospitals of North Midlands NHS Trust (hereafter called "the Trust") in which University clinical academic staff may hold honorary NHS contracts and Hospital Consultants may hold honorary University contracts, and it provides a framework for co-operation between the University and Trust as employers of the clinical academic staff.

General Principles

2. The substantive contract and the honorary contract are both contracts of employment. The clinical academic will therefore have two employers, each of whom will have obligations to the employee under its respective contract of employment and arising (for example under statute) from the employment relationship generally.

3. However, the University and the Trust recognise that as far as possible those separate employment relationships should be regarded as a whole, reflecting the fact that the performance of both the clinical duties and the academic duties under both contracts is essential for the full and proper performance of the duties.

4. The University and the Trust therefore seek to ensure that joint co-operation in their dealings with the member of clinical academic staff, in particular with regard to issues of appraisal, review, dismissal and discipline.

5. The Trust and the University will apply their own procedures to the aspects of the contract that they hold.

Contracts of Employment

6. The University and the Trust have ensured that their contracts (honorary or substantive) contain provisions which facilitate joint co-operation and discuss on a regular basis the contents of the contracts which each will issue to clinical academics.

Disciplinary and other Procedures

7. The University and the Trust acknowledge that as employers of the clinical academic member of staff, each may wish, during the employment of the clinical academic concerned, to take action (whether in terms of dismissal or action falling short of dismissal) in respect of matters such as:

    a) misconduct or alleged misconduct

    b) performance of the duties of employment to a satisfactory standard

    c) assessing medical fitness to undertake all or part of the duties of employment (including consideration of the making of reasonable adjustments under the disability Discrimination Act 1995 where the obligation to make such adjustments applies)

    d) attendance

    e) redundancy or other re-organisation

8. The University and the Trust acknowledge that each has the following procedures for determining such issues in respect of its relationship with the member of clinical academic staff:

University Hospitals of North Midlands NHS Trust
HR01 Disciplinary Procedure
HR18 Disciplinary and Management of Performance Policy and Procedure for Medical and Dental Staff
HR14 Attendance Policy

Keele University

The University's Statutes – Section 35 Part III – Discipline, Dismissal and Removal from Office

9. The University and the Trust acknowledge that:

a) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s), and the Trust does not (and *vice versa*);

b) there may be occasions on which the University has grounds for considering such action under its appropriate procedure(s) and the Trust also has grounds for considering action against the same employee under its own appropriate procedure(s); and

c) if the University or the Trust terminates the substantive or honorary contract (as the case may be), the other will need to consider whether, in the light of that termination, the remaining contract can be continued or ought to be terminated and that, while each case will need to be considered on its own facts, it is appropriate for the University and the Trust to agree in general terms a framework for the handling of such matters.

10. The University and the Trust therefore agree that:

a) the following issues of conduct are matters which would ordinarily fall to be dealt with under the University's disciplinary procedure(s);

- Conviction for an offence which may be deemed by a Tribunal appointed by the University to be such as to render the person convicted unfit for the execution of the duties of the office or employment as a member of the academic staff; or
- Conduct of an immoral, scandalous or disgraceful nature incompatible with the duties of the office or employment; or
- Conduct constituting failure or persistent refusal or neglect or inability to perform the duties or comply with the conditions of office; or
- Physical or mental incapacity established under Part IV of the Statutes.

b) The following issues of conduct are matters which would ordinarily fall to be dealt with under the Trust's disciplinary procedure(s);

- poor timekeeping;
- breaches of confidentiality;
- failure to follow reasonable instructions;

- misuse of Trust facilities;
- use of inappropriate language;
- theft
- damage to property
- fraud
- incapacity for work due to being under the influence of alcohol or drugs
- physical violence
- bullying
- gross insubordination
- misuse of the Trust's property or resources, (including excessive personal use or inappropriate use of the internet or e-mail facilities contrary to Trust policy
- knowingly importing onto the Trust's computer systems and/or distributing, offensive and/or pornographic material or virus/es bringing the Trust into serious disrepute and/or causing a break-down in the relationship between employer and/or employee and/or fellow employees
- serious breach of confidence (subject to the Public Interest Disclosure Act 1998 which is referred to in the Whistleblowing Procedure) including deliberately divulging to the media or a competitor, Trust confidential and/or business sensitive information serious infringement of Health & Safety rules breach of civil or criminal law. In the case of criminal offences, where such offences (whether committed during or outside the employee's hours of work for the Trust) adversely affects the Trust's reputation, the employee's suitability for the type of work he or she is employed by the Trust to perform or his or her acceptability to other employees or to patients or students.

The above lists, which are not intended to be exhaustive, provide examples of offences that are regarded as misconduct. The classification of gross or minor misconduct will depend upon the severity and nature of the offence. Each case must be considered on its own merits.

c) in cases where an issue of misconduct arises under both (a) and (b) above, the University and the Trust will need to determine on the facts of each case which procedure will take priority.

Potential Dismissal on the Grounds of Misconduct

11. When either the University or the Trust has grounds for considering the dismissal of a member of clinical academic staff on the grounds of misconduct:

a) the Human Resources Director or Deputy Director and Medical Director/Head of School of Medicine considering the instigation of disciplinary procedures which may result in dismissal will notify their counterparts within the other organisation of that fact and will discuss with the other the circumstances which have led it to contemplate initiating proceedings.

b) the University and the Trust will co-operate with each other to facilitate any investigation into the alleged misconduct.

c) the University and the Trust will consider whether the case is such that both parties would have grounds for instituting disciplinary proceedings and, if that is the case, agree the most appropriate way forward in terms of action to be taken and the sequence in which this occurs.

d) any party considering restriction of practice or exclusion from work of the clinical academic will advise the other of its proposal and discuss this prior to the clinical academic being restricted or excluded where it is practical to do so.

e) the University and the Trust will liaise with each other on the steps to be taken under the applicable disciplinary procedure or procedures. In particular they will discuss:

- representation by both employers on any disciplinary panel established under any of their applicable procedures
- the facilitation of the calling of witnesses
- the production of documentary evidence necessary for the purpose of determining whether misconduct has occurred.

f) the University and the Trust (as the case may be) will keep the other informed of the progress and outcome of their respective procedures, including any appeal and outcomes arising from this.

12. Whilst the University and the Trust will co-operate with each other as described above, each acknowledges that the other has the ultimate right to determine whether or not disciplinary proceedings should be instigated, to determine whether misconduct has occurred and, if so, whether dismissal is the appropriate sanction to be applied on the facts of that case. Representation of the Trust on the University's disciplinary panels (and *vice versa*) does not mean that the Trust's representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and vice versa).

Joint Appraisal

13. The University and the Trust have agreed procedures for the joint appraisal of members of clinical academic staff and these arrangements are referred to in the terms of the substantive and honorary contracts issued to the member of staff.

Dismissal on Performance, Absence or Ill-Health Grounds

14. In the event that either the Trust or the University considers that there are grounds for considering the dismissal of a member of clinical academic staff on the grounds of performance, absence or health grounds, the Human Resources Director or Deputy Director will advise the other of that fact and shall discuss:

a) whether action is be taken under the procedures of the University or the Trust or both (and, if both, which procedure shall take priority);

b) whether it is appropriate to consider the restriction of practice or exclusion from work of the member of staff concerned in relation to either the academic or clinical duties or both. Any party considering restriction of practice or exclusion from work of the clinical academic member of staff shall advise the other if it is proposed to restrict or exclude, and discuss this prior to the clinical academic member of staff being restricted or excluded where it is practical to do so; and

c) (in cases of sickness absence, or medical incapacity) whether it is necessary to obtain a medical report from an Occupational Health advisor or from an independent medical expert on the ability of the employee to perform the duties of his/her employment. The University and the Trust will discuss the questions/issues to be raised with the medical advisor, in particular any issues arising under the Disability Discrimination Act 1995, including any duty to make reasonable adjustments.

15. The University and the Trust will keep each other advised of the actions taken under their applicable procedures, including the outcome of any appeal.

16. Whilst the University and the Trust will co-operate with each other as described above, each acknowledges that the other has the ultimate right, in relation to any matter being dealt with under its procedures, to determine whether or not to dismiss the member of staff concerned. Representation of the Trust on the University panel (and vice versa) does not mean that the representative is deciding whether the Trust's contract with the member of staff concerned is to be terminated (and vice versa).

Dismissal on the grounds of redundancy or re-organisation

17. In the event that either the Trust or the University is contemplating a dismissal for redundancy or other re organisational reasons of any member of clinical academic staff, it will advise the other of this fact and will keep the other regularly informed of the action being taken in this respect.

Other General Provisions Regarding Co-operation

18. The University and Trust will ensure that:

    a) their respective procedures provide that, while either the University's or the Trust's disciplinary procedure is being applied to a member of clinical academic staff, that individual may not bring any complaint relating to those proceedings under the grievance procedure of the other employer (i.e. of the Trust or the University, as the case may be).

    b) rights of appeal will be confined solely to the procedure which is being implemented and individual employees may not appeal across procedures to the other party (i.e. the University or the Trust as the case may be).

    c) their contracts of employment and procedures are as far as possible sufficient to allow the disclosure of information from one to the other (in particular personal data or sensitive personal data) under Data Protection. In these circumstances the individual concerned would be advised that information will be shared across both organisations. The Trust and the University will also discuss and agree guidelines for the disclosure of data regarding third parties, in particular data relating to patients. (N.B. Confidential patient information can not be shared without the patient's permission).

9. The University and the Trust will meet on a regular basis to review this Agreement and its operation.

PROCEDURE FOR MANAGING ALLEGATIONS AGAINST PEOPLE WHO WORK WITH CHILDREN

Scope

1. This procedure applies to a wider range of allegations than those in which there is reasonable cause to believe a child is suffering, or is likely to suffer, significant harm. It also applies to cases of allegations that might indicate that the alleged perpetrator is unsuitable to continue to work with children in his or her present position, or in any capacity. It should therefore be used in respect of all cases in which it is alleged that a person who works with children has:

    - behaved in a way that has harmed, or may have harmed, a child
    - possibly committed a criminal offence against, or related to, a child; or
    - behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.

2. There may be up to three strands in the consideration of an allegation:
    - a police investigation of a possible criminal offence;
    - enquiries and assessment by children's social care about whether a child is in need of protection or in need of services;
    - consideration by the Trust, as the employer, of disciplinary action in respect of the individual.

3. This procedure applies to all staff and volunteers.

Supporting those involved

4. Parents, or carers of a child or children involved, should be informed of the allegation as soon as possible. They should also be kept informed about the progress of the case, and advised of the outcome where there is no criminal prosecution. This includes the outcome of any disciplinary process.

    Note: the deliberations of a disciplinary hearing, and the information taken into account in reaching a decision, cannot normally be disclosed, but those concerned should be told the overall outcome.

5. The Trust will also keep the person who is the subject of the allegations informed of the progress of the case, and arrange to provide appropriate support to the individual while the case is on-going. (That support may be provided via occupational health or the Staff Support Service). If the person is suspended/excluded, the Trust will also make arrangements to keep the individual informed about developments in the workplace. If the person is a member of a union or professional body, they should be advised to contact that body at the outset.

Confidentiality

6. Every effort will be made to maintain confidentiality and guard against publicity while an allegation is being investigated/considered. The police do not normally provide any information to the press or media that might identify an individual who is under investigation, unless and until the person is charged with a criminal offence.

Resignations and 'compromise agreements'

7. The fact that a person tenders his or her resignation, or ceases to provide their services, will not prevent an allegation being followed up in accordance with this procedure. Every effort will be made to reach a conclusion in all cases of allegations

bearing on the safety or welfare of children, including any in which the person concerned refuses to co-operate with the process. Wherever possible, the person should be given a full opportunity to answer the allegation and make representations about it. If a person's period of notice expires before the process is complete, the process of investigation will need to continue, on the basis of all the information available, and it is important to reach and record a conclusion wherever possible.

8. 'Compromise agreements*' must not be used in these cases. It should be noted that, if such an agreement was used it will not prevent a thorough police investigation where appropriate, nor can it override an employer's statutory duty to make a referral to the Protection of Children Act List or DfES List 99 where circumstances require it. (See paragraphs 12.29 and 12.33 of the document 'Working Together to Safeguard Children': a guide to interagency working to safeguard and promote the welfare of children 2006 for more information). www.everychildmatters.gov.uk

* (i.e. whereby a person agrees to resign, the Trust agrees not to pursue disciplinary action, and both parties agree a form of words to be use in any future reference.)

Record-keeping

9. The Trust will keep a clear and comprehensive summary of any allegations made, details of how the allegations were followed up and resolved, and of any action taken and decisions reached. These should be kept in a person's confidential personnel file and a copy should be given to the individual. Such information should be retained on file, including for people who leave the organisation, at least until the person reaches normal retirement age, or for 10 years if that is longer. The purpose of the record is to enable accurate information to be given in response to any future request for a reference. It will provide clarification in cases where a future CRB Disclosure reveals information from the police that an allegation was made but did not result in a prosecution or a conviction. It will also prevent unnecessary re-investigation if, as sometimes happens, allegations resurface after a period of time.

The Trust has an obligation to share information with the Local Authority Designated Officer (LADO).

Timescales

10. It is in everyone's interest to resolve cases as quickly as possible, consistent with a fair and thorough investigation. Every effort will be made to manage cases to avoid any unnecessary delay. The time taken to investigate and resolve individual cases depends on a variety of factors, including the nature, seriousness and complexity of the allegations.

Oversight and monitoring

11. In line with the Trust's Whistleblowing Policy, allegations or concerns that a member of staff or volunteer may have abused a child can be reported to the Chief Nurse or in her absence, the Trust's Chief Operating Officer. These officers are responsible for providing advice and liaison and monitoring the progress of cases, to ensure that cases are dealt with as quickly as possible and that they are consistent with a fair and thorough process. Specialist advice is available from the Trust's Child Protection leads who can be contacted on extension (55) 2156 and who will act as Trust Senior Manager for child protection in these procedures.

Suspension/Exclusion

12. The possible risk of harm to children posed by an accused person needs to be evaluated and managed effectively – in respect of the child(ren) involved in the allegations, and any other children in the individual's home, work or community life. In some cases this requires the Trust to consider suspending the person. Suspension/exclusion should be considered in any case where there is cause to suspect a child is at risk of significant harm, or the allegation warrants investigation by the police, or is so serious that there may be grounds for dismissal. People must not be suspended/excluded automatically or without careful thought. The Trust will consider carefully whether the circumstances of a case warrant a person being suspended from contact with children until the allegation is resolved.

    Note:

    Neither the Local Authority, nor the police, nor children's social care can require the Trust to suspend a member of staff or a volunteer. The power to suspend is vested in the Trust alone. However, where a strategy discussion or initial evaluation discussion concludes that there should be enquiries by social care and/or an investigation by the police, the Local Authority's Designated Officer (LADO) will canvass police/social care views about whether the member of staff needs to be suspended/excluded from contact with children, to inform the Trust's consideration of suspension/exclusion.

PROCESS (See Attached Flowchart)

Allegation made to Trust

13. The allegation should be reported immediately to the Chief Nurse/Chief Operating Officer as identified in the Trust's Whistleblowing Policy (i.e. Trust Senior Officer). The Trust Senior Manager for Child Protection will be informed.

14. If the allegation meets any of the criteria set out in paragraph 1 of this procedure, the allegation will be reported to the Local Authority Designated Officer within one working day.

Allegation made to the police or children's social care

15. If an allegation is made to the police, the officer who receives it will report it to the force's designated liaison officer without delay, and the designated liaison officer should, in turn, inform the Local Authority Designated Officer. Similarly, if the allegation is made to children's social care, the person who receives it should report it to the Local Authority Designated Officer without delay.

Initial consideration

16. The Local Authority Designated Officer will discuss the matter with the Trust Senior Manager for Child Protection, the Chief Nurse/ Chief Operating Officer and Human Resources Director as appropriate and, where necessary, obtain further details of the allegation and the circumstances in which it was made. The discussion should also consider whether there is evidence/information that establishes that the allegation is false or unfounded.

17. If the allegation is not patently false and there is cause to suspect that a child is suffering, or is likely to suffer, significant harm, the Local Authority Designated Officer will immediately refer to children's social care and ask for a strategy discussion to be convened straightaway. In these circumstances, the strategy discussion should include the Local Authority Designated Officer and representative of the Trust e.g. (Chief

Nurse and Human Resources Director) and the Trust Senior Manager for Child Protection.

18. If there is no cause to suspect that 'significant harm' is an issue, but a criminal offence might have been committed, the Local Authority Designated Officer will immediately inform the police and convene a similar discussion, involving Trust representatives, including the Director of Human Resources, to decide whether a police investigation is needed.

Action following initial consideration

19. Where the initial evaluation decides that the allegation does not involve a possible criminal offence, the allegation will be dealt with by the Trust. In such cases, if the nature of the allegation does not require formal investigation an appropriate response should be instituted **within three working days**.

20. Where further investigation is required to inform consideration of disciplinary action, Trust representatives will discuss who will undertake that with the Local Authority Designated Officer.

21. The investigation will be conducted in accordance with the Trust's Disciplinary Policy and Procedure.

22. In any case in which children's social care has undertaken enquiries to determine whether the child or children are in need of protection, the Trust will take account of any relevant information obtained in the course of those enquiries when considering the need for action in accordance with the Trust Disciplinary Policy.

23. The Local Authority Designated Officer will continue to liaise with the Trust representatives to monitor progress of the case and provide advice/support when required or requested.

Case subject to police investigation

24. If a criminal investigation is required, the police will aim to complete their enquiries as quickly as possible, consistent with a fair and thorough investigation, and will keep the progress of the case under review. They should, at the outset, set a target date for reviewing progress of the investigation and consulting the Crown Prosecution Service (CPS) about whether to proceed with the investigation, charge the individual with an offence, or close the case. Wherever possible that review should take place **no later than four weeks** after the initial evaluation, and if the decision is to continue to investigate the allegation, dates for subsequent reviews should be set at that point.

25. If the police and/or CPS decide not to charge the individual with an offence, or decide to administer a caution, or the person is acquitted by a court, the police are expected to pass all information they have which may be relevant to a disciplinary case to the Trust without delay. In these circumstances the Trust and the Local Authority Designated Officer will proceed as described in paragraphs 19-23 above.

26. If the person is convicted of an offence, the police will inform the Trust straightaway so that appropriate action can be taken. The Director of Human Resources/Deputy Director of Human Resources must be contacted in these circumstances.

Protection of Children Act List/DfES List 99/Referral to PoCA list or regulatory body

27. If the allegation is substantiated, and on conclusion of the case the Trust dismisses the person or ceases to use the person's services, or the person ceases to provide his/her services, the Trust will consult the Local Authority Designated Officer (LADO) about whether a referral to the PoCA list and/or to a professional or regulatory body is required. If a referral is appropriate, the report will be made within one month.

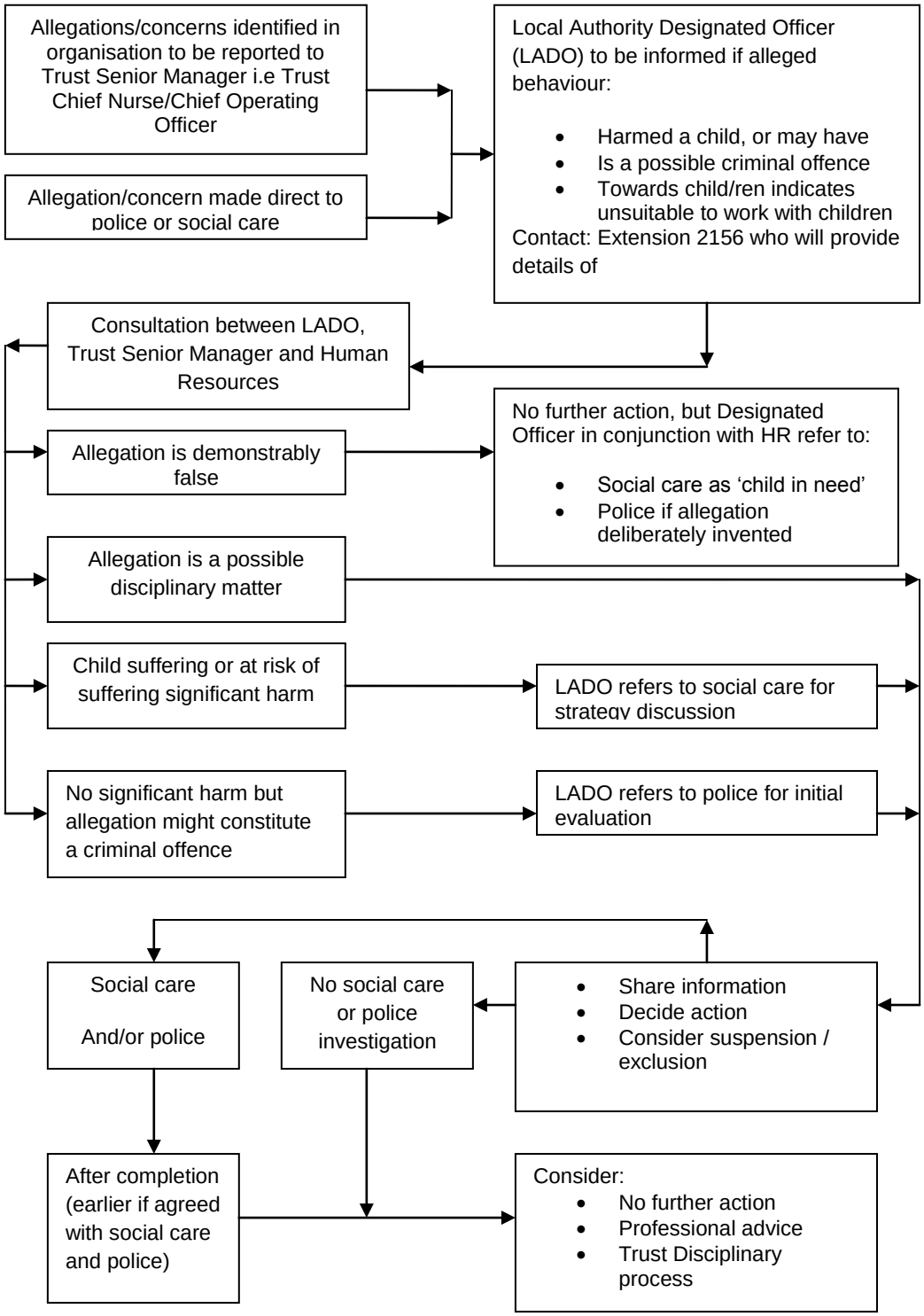
Learning lessons

28. At the conclusion of a case in which an allegation is substantiated, the Trust will review the circumstances of the case to determine whether there are any improvements to be made to the organisation's procedures or practice to help prevent similar events in the future.

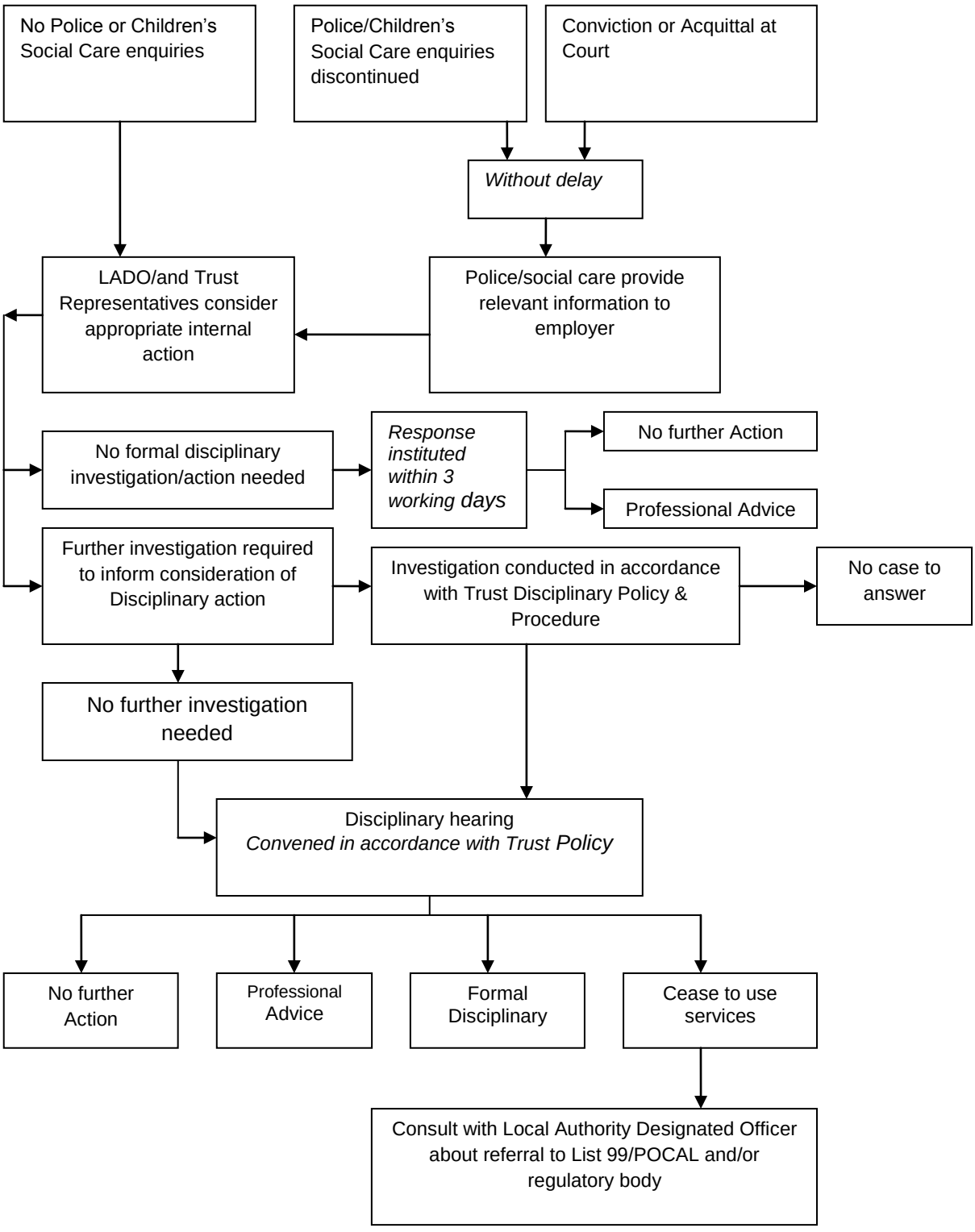
Action in respect of false or unfounded allegations

29. If an allegation is believed to be unfounded, the Trust will refer the matter to children's social care to determine whether the child concerned is in need of services, or may have been abused by someone else. In the rare event that an allegation is shown to have been deliberately invented or malicious, the police should be asked to consider whether any action might be appropriate against the person responsible.

ALLEGATIONS/CONCERNS ABOUT STAFF AND VOLUNTEERS
CHILD PROTECTION PROCESS



ALLEGATIONS/CONCERNS ABOUT STAFF AND VOLUNTEERS DISCIPLINARY/SUITABILITY PROCESS



Signed: **……**
(on behalf of the Trust)

Date: **……**

Signed: **……**
(on behalf of the LNC)

Date: **……**