University Hospitals Bristol NHS
NHS Foundation Trust

Policy for Managing Capability Concerns of Medical and Dental Staff

Document Data		
Subject:	Concerns regarding the performance of medical and dental staff	
Document Type:	Policy	
Document Status:	Approved	
Document Owner:	Associate Director of HR	
Executive Lead:	Medical Director	
Approval Authority:	Trust Partnership Forum	
Estimated Reading Time:	'35' Minutes[1]	
Review Cycle:	36 Months	
Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
Sept 2019	Nov 2012	Sept 2016

Document Abstract
Concerns regarding the performance of medical and dental staff should be dealt with in a manner which is proportionate to the level of concern. This policy applies to all medical and dental staff within the Trust, ordinarily excluding doctors in training, who will be supported with the assistance of the Deanery in the first instance.

[1] Divide number of words (8518) by 240 for average reading time and add 25% for specialist content.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
01/11/2012	V1	Associate Director of HR	Major	First draft
08/09/2016	V3	Associate Director of HR	Minor	Review

The master document is controlled electronically. Printed copies of this document are not controlled. Document users are responsible for ensuring printed copies are valid prior to use.

Table of Contents

1. Introduction 5
2. Purpose and Scope 6
3. Definitions 7
   - 3.1 Case Manager 7
   - 3.2 Designated Member 7
   - 3.3 Case Investigator 7
   - 3.4 HR Support 7
4. Duties, Roles and Responsibilities 7
5. Policy Statement and Provisions 8
   - 5.1 Case Investigations 8
   - 5.2 Timeframe of the investigation 8
   - 5.3 Process for Informal Management 9
   - 5.4 Serious performance concerns 9
6. Support for Practitioners with Ill Health 9
   - 6.6 Reasonable adjustments 10
7. Conduct and Disciplinary Matters 10
8. Process – Setting Up a Capability Hearing 11
   - 8.1 Principles 11
   - 8.2 Pre-hearing process 11
   - 8.3 Procedure to be followed for a capability hearing panel 11
   - 8.4 The Panel 12
   - 8.5 The Capability Hearing 12
   - 8.6 Capability hearing proceedings 13
   - 8.7 Possible capability panel outcomes 13
   - 8.8 Appeal against capability panel decision 14
   - 8.9 Review 14
   - 8.10 Equality Impact Assessment (EIA) statement 15
9. References 15
10. Associated Documentation 16
    - 10.1 Quick Reference Guide – Process Flowchart 16
    - 10.2 Resources available for remediation 17
    - 10.3 Process for Exclusion 19
    - 10.4 Use of ‘Exclusion’ 19

10.5 Purpose of 'Exclusion' 19
10.6 Alternatives to exclusion 19
10.7 Action plan feasibility 20
10.8 Key features of exclusion from work 20
10.9 Immediate exclusion 20
10.10 Formal exclusion 20
10.11 Exclusion from the premises 22
10.12 Keeping in contact 22
10.13 Informing other organisations 22
10.14 Keeping exclusions under review – Informing the Board 22
10.15 Regular review 22
10.16 Return to work 23
11. Appendix A – Dissemination, Implementation and Training Plan 24
12. Appendix B – Document Checklist 25

1. Introduction

1.1 The performance of medical and dental staff can be affected by a variety of factors including acute/chronic physical ill health or emotional and psychological influences.

1.2 Information should remain confidential and should only be shared with relevant parties.

1.3 For serious concerns, or when informal action has not improved performance, assistance from the Medical Director/Deputy Medical Director should be sought.

1.4 Obtaining external sources of advice (e.g. NCAS, GMC Employment Liaison Officer, GDC, Royal Colleges & Specialty Associations) should be considered at an early stage.

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

(a) Concerns expressed by other NHS professionals, health care managers, students and non-clinical staff

(b) Review of performance against job plans and at annual appraisals

(c) Monitoring of performance data

(d) Clinical governance, clinical audit and other quality improvement activities

(e) Complaints about care of patients and behaviours effecting patient care, by patients or relatives of patients

(f) Information from regulatory bodies

(g) Litigation following allegations of negligence

(h) Information from the police or coroner

(i) Court judgements

1.6 Unfounded and malicious allegations can cause lasting damage to a doctor's/dentist's professional reputation and career prospects. Therefore all allegations must be fairly, reasonably, proportionately investigated and addressed.

1.7 The Trust will investigate any aspect of a practitioner's performance which:

(a) Poses a threat or potential threat to patient safety

(b) Exposes the organisation's services to financial or other risk

(c) Significantly undermines the reputation or efficiency of services

(d) Is outside acceptable practice guidelines and standards (both GMC/GDC professional standards and Royal College/Specialty standards).

(e) Poses a threat to their own or their colleagues safety or well – being.

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

(g) Behaviours not in line with the Trust's values and the Staff Conduct Policy.

1.8 The Trust will ensure that investigations and performance procedures are conducted in a way that does not discriminate on the grounds of any characteristics covered by the Equality Act 2010.

1.9 Staff involved in investigating performance or conduct concerns must be appropriately experienced.

1.10 This policy has been developed in line with the Department of Health (DoH) 2005 national framework - 'Maintaining High Professional Standards in the Modern NHS'; the National Clinical Assessment Service (NCAS) 2010 good practice guide and 'The Back On Track framework for further training guide.

1.11 This policy provides a number of processes which allow for the most appropriate and proportionate action to be taken depending on the circumstances of the case.

2. Purpose and Scope

2.1 All concerns should be dealt with in a manner proportionate to the level of concern. All concerns should be considered on all of the information available, and where appropriate, managed informally between the practitioner and their line manager. Consideration must be given to the necessity of informing the Clinical Chair, Divisional Director, HR Business Partner or Medical Director/Deputy Medical Director.

2.2 Serious concerns must be raised with the Medical Director, who will register the concerns with the Chief Executive. Serious concerns should be fully investigated in a timely manner.

2.3 When serious concerns are raised about a practitioner consideration should be given to whether it is necessary to place temporary restrictions on the doctor/dentist. This might be to amend or restrict their clinical duties, obtain undertakings or exclude the practitioner from the workplace (see Appendix B – Exclusion Process).

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

2.5 If at any point in the process, the Clinical Chair/Medical Director or nominated Case Manager considers the practitioner to be a potential or actual risk to patients or staff, the practitioner must be referred to the appropriate regulatory body. In the first instance this may include requesting advice from the regional GMC Employment Liaison Officer. In high risk situations, the Medical Director/Deputy Medical Director should give consideration to the appropriateness of issuing an alert letter to healthcare agencies where the practitioner may have clinical duties.

2.6 If significant performance concerns become evident during an appraisal, the appraiser must immediately suspend the appraisal and ensure the appraisee understands why the appraisal has been halted.

2.7 At all formal/informal stages under this Policy the practitioner should be afforded the right to representation and/or support. This can be by a trade union/professional association representative not acting in a legal capacity and/or a workplace colleague or spouse.

2.8 At any stage in the management of concerns, consideration should be given to the involvement of external agencies for information, advice and support. These may include NCAS, GMC/GDC, Royal Colleges or Specialty Associations. If a formal referral to NCAS is required this will be made by either the Medical Director or Chief Executive. Ordinarily, NCAS will be consulted with prior to instigating formal action against a doctor or dentist.

2.9 Complex cases may require the Trust to consult with legal advisors as it considers necessary to ensure the proposed action is appropriate.

2.10 Any timescales referred to in this policy are calendar days.

3. Definitions

3.1 Case Manager

(a) The person responsible for reviewing the information available, assessing the facts and identifying the most appropriate action based on the processes set out in this policy.

(b) The Medical Director will act as case manager in cases involving Clinical Chairs and he/she may delegate this role to a senior medical/clinical manager or deputy medical director in other cases. The Case Manager will appoint a Case Investigator where necessary and they will confirm the terms of reference for an investigation if required.

3.2 Designated Member

(a) A non-executive director (nominated by the Chairman) who oversees the case to ensure that momentum is maintained.

3.3 Case Investigator

(a) The person identified to lead the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The Medical Director is responsible for appointing a case investigator and ensuring there is no conflict of interest. The case investigator must formally involve a senior doctor/dentist where a question of clinical judgement is raised during the investigation process.

(b) The case investigator needs to be appropriately experienced and must endeavour to preserve confidentiality as far as reasonably possible during the investigation. Patient confidentiality needs to be maintained but the investigation report needs to clearly show the details of the allegations.

(c) It is the responsibility of the case investigator to work to the terms of reference set by the case manager and assess what information needs to be gathered and how.

(d) The case investigator needs to ensure that sufficient evidence is collected to meet the requirements set out in the terms of reference so that the allegations can be fully considered and a robust and appropriate decision can be made by the case manager.

(e) The case investigator may not be a member of any formal hearing panel sitting in judgement on a case.

3.4 HR Support

(a) The case investigator will be supported by an appropriately trained and experienced HR practitioner.

4. Duties, Roles and Responsibilities

4.1 All doctors and dentists have a professional and contractual responsibility to perform their duties to an acceptable standard as set out by the General Medical Council or General Dental Council, and the relevant Royal College/Specialty Association as applicable.

4.2 The Trust has an obligation to support and enable doctors and dentists to achieve these standards. This includes providing appropriate remedial resources and support when concerns are identified.

5. Policy Statement and Provisions

5.1 Case Investigations

(a) The purpose of the investigation is to ascertain the facts in an unbiased manner.

(b) The case investigator has wide discretion in how the investigation should be carried out.

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

(d) If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider whether an independent practitioner from another NHS body should be invited to assist the investigation. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional misconduct, the case investigator may obtain independent professional advice from a senior practitioner in the same specialty. (the Case Manager should be consulted when identifying suitable advisors).

(e) If the case investigator considers that key lines of enquiry need to go beyond the original terms of reference set by the case manager – he/she should request that the case manager amends the terms of reference.

(f) It is usual for the case investigator to interview witnesses with HR support .In some cases, in order to expedite the investigation, where appropriate ,witnesses may be interviewed by the case investigator without HR support.

(g) When interviewing witnesses, the investigator should remain objective and avoid leading the witness through inappropriate questions, feedback or comment. At the end of the interview the practitioner should be asked if there is anything else that they wish to add to the information they have given. Following the interview, witnesses should be given written meeting notes and asked to confirm that they are an accurate record. In general there is no need for a witness to be formally represented, however a supportive colleague/ friend/ spouse/ trade union representative may be present and practitioners will be advised of their entitlement to such representation.

(h) Having compiled the evidence the case investigator should set out the facts as they see them based on the 'balance of probabilities' test. The more serious the concerns about the doctor/dentist the greater the need for the case investigator to be satisfied that the evidence supports their findings.

5.2 Timeframe of the investigation

(a) The case investigator should complete the investigation as soon as possible and ordinarily within 28 calendar days of commencement. Due to clinical commitments and leave this timescale is not always possible.

(b) Following completion of the investigation the report should be submitted to the case manager within a further 7 calendar days. When the case manager receives the report he/she will send the report to the doctor/dentist to give them an opportunity to comment on the factual content of the report produced by the case investigator. The practitioner must submit any comments in writing to the case manager within 14 calendar days from receipt of the request.

(c) Where an investigation establishes suspected criminal wrong-doing in the UK or abroad, the Case Manager in conjunction with the Medical Director will assess whether the police and the GMC/GDC should be notified. If the police is notified, the Trust will consult with them as to whether the Trust's and the Police's investigations can run concurrently without any impediment or obstruction to either. In cases of fraud, the Counter Fraud and Local Security Management Service will be notified.

5.3 Process for Informal Management

(a) When performance concerns are raised an initial meeting will take place between the practitioner and the Clinical Director to agree a SMART Action Plan and timescales for monitoring. The Clinical Director will have discussed this with the Clinical Chair and HR Business Partner if necessary. At this meeting the performance concerns will be discussed and clarified. Where appropriate, evidence may be provided (e.g. incident forms, patient complaints etc).

(b) The presence and potential impact of any “distracters” i.e. factors which may adversely influence performance, must be explored and documented. The doctor/dentist will have the opportunity to consider allegations regarding their performance and to raise any mitigating factors, particularly relating to team or organisational context. If department/divisional/Trust factors are identified as adversely affecting their performance - the Clinical Director should raise these with the relevant person who is able to address these factors, and agree an organisational recovery action plan.

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

(d) Arrangements for subsequent meetings to review performance against the action plan/timescales should be agreed between both parties. This should be backed up with evidence and supporting statements. Where the action plan has been achieved, no further action will be taken and this will be confirmed in writing to the practitioner.

(e) If the action plan has not been achieved, a decision needs to be taken on whether there are mitigating reasons for this, and whether the time frames and/or actions should be amended. In this case a further review period should be agreed.

(f) If it is felt by the line manager that the practitioner has failed to meet the reasonable requirements of the action plan, or indeed not taken the process seriously, the case should be raised with the Divisional Director, Clinical Chair, Medical Director and Human Resources Business Partner. Failure to comply with the agreed action plan without good reason (e.g. work absence due to ill health) or the presence of continuing adverse events or behaviour will result in initiation of the serious performance concerns process (see below).

(g) The contents of the meeting will be documented, and provided to the doctor/dentist within seven calendar days of the date of the meeting, alongside a copy of the agreed action plan. A copy (including action plan) should be sent to the Medical Director, Divisional Director and Clinical Chair for information.

5.4 Serious performance concerns

(a) In serious cases of unsatisfactory performance, particularly where there are patient safety issues, lack of insight or failure of progress on previous remedial action plans - the Divisional Director, Clinical Chair and Medical Director must be informed. The Medical Director will consider whether it is necessary to place temporary restrictions on a practitioner’s practice and consider whether a referral to the GMC/GDC is appropriate. The Medical Director should also give consideration to the issuing of an alert letter to other NHS organisations.

6. Support for Practitioners with Ill Health

6.1 Where there is an incident that points to a problem with the practitioner’s health, the Clinical Chair/Clinical Director must immediately refer the practitioner to a qualified Consultant in Occupational Health Medicine. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Clinical Chair/Clinical Director. A meeting should be convened with the Clinical Chair/Clinical Director or case manager, HR Business Partner, the practitioner and Occupational Health

practitioner to agree a timetable of action and rehabilitation (where appropriate). The practitioner may wish to be accompanied to these meetings by a family member, a colleague or a trade union/professional association representative. Confidentiality must be maintained by all parties at all times.

6.2 If a doctor or dentist's ill health makes them a danger to patients which they do not

6.3 recognise, or are not prepared to co-operate with measures to protect patients, then exclusion from work (in line with Maintaining High Professional Standards in the Modern NHS DH 2005) and referral to the GMC/GDC should be considered, irrespective of whether or not they have retired on the grounds of ill health.

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

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

6.6 Reasonable adjustments

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

- Making adjustments to the premises;
- Re-allocating some of a disabled person's duties to another;
- Altering an employee's working hours or pattern of work;
- Assigning the employee to a different workplace;
- Allowing absence for rehabilitation, assessment or treatment;
- Providing additional training or retraining;
- Acquiring/modifying equipment;
- Modifying procedures for testing or assessment;
- Providing a reader or interpreter
- Transferring the practitioner to an existing vacancy

(b) In some cases an ill health retirement application to the NHS Pensions Agency may be appropriate. This should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency guidelines. However, any issues relating to capability that have arisen must first be resolved, using the appropriate agreed procedures, or reported to the GMC/GDC as appropriate.

7. Conduct and Disciplinary Matters

7.1 Allegations of a general misconduct nature will be managed in accordance with the Trust's general Disciplinary Policy and Procedure..

8. Process – Setting Up a Capability Hearing

8.1 Principles

(a) The influence of physical and mental health issues on a practitioner's capacity must always be considered in any capability investigation. There must be early referral for occupational health assessment (see Section 8) if issues are identified.

(b) The context of team dynamics with divisional and organisational factors must also be considered.

(c) Engagement with NCAS and the GMC ELO must be timely and approaching the relevant Royal College/Specialty associations along with other sources of advice may also be helpful.

(d) There may be overlap with conduct issues and standards of professional behaviour.

(e) In the event of a dispute of the nature of the concerns and the appropriateness of the procedure used to manage them, the practitioner is entitled to use the Trust's Grievance procedure and /or make representations to the Designated Board member if they feel their case has been wrongly classified.

8.2 Pre-hearing process

(a) Once the report of the investigation is prepared, the case manager must give the practitioner the opportunity to study the content and provide written comment. This must be submitted to the case manager within 14 calendar days of receipt. This time limit may be altered in exceptional cases with the prior agreement of the case manager.

(b) The Case Manager will, taking all sources of information into account (e.g. from NCAS) and after consultation with the Director of Workforce and Organisational Development or nominated deputy, decide what further action is necessary and develop an action plan accordingly. The Case Manager will inform the practitioner of the decision at the earliest possible opportunity and normally within 14 calendar days of receiving the practitioner's comments.

8.3 Procedure to be followed for a capability hearing panel

(a) The case manager must notify the practitioner in writing of the decision to arrange a capability hearing to consider the case against him/her. This notification should be made at least 28 calendar days before the hearing. It will include details of the allegations, who is on the panel and the arrangements for the proceedings including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability hearing panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing, if they so choose.

(b) All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 14 calendar days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing.

(c) Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. The Trust retains the right, after a reasonable period (not less than 42 calendar days), to proceed with the hearing in the practitioner's absence, although the Trust will act reasonably in deciding to do so, taking into account any comments made by the practitioner.

(d) Should the practitioner's ill health prevent the hearing taking place, the Trust will implement its usual absence procedures and involve the Occupational Health Department as necessary;

(e) witnesses who have made written statements at the inquiry stage may be required to attend the capability hearing. If the organisation or the practitioner contests a witness statement which is to be relied upon in the hearing, the Chairman will invite the witness to attend. The Chairman cannot

require anyone other than an employee to attend. However, if evidence is contested and the witness is unable or unwilling to attend, the panel will reduce the weight given to the evidence as there will not be the opportunity to challenge it properly. A final list of witnesses to be called must be given to both parties not less than two calendar days before the hearing.

(f) A person accompanying a witness cannot participate in the hearing.

8.4 The Panel

(a) The panel will comprise 3 people, normally 2 members of the Trust board or other senior staff appointed by the board for the purpose of the hearing. The panel will be chaired by an Executive Director of the Trust. One member must be an independent medical or dental practitioner not employed by the Trust. The members of the panel should not have been involved with the investigation.

(b) The panel will take advice from the independent medical/dental panel member on the appropriate level of competence expected, and a senior HR practitioner and a senior representative of the University (for clinical academics) will be available to the panel as required.

(c) The practitioner may raise an objection to the choice of panel member within 5 working days of notification. The Trust will take reasonable measures to ensure that the membership of the panel is acceptable to the practitioner. It may be necessary to postpone the hearing while this matter is resolved.

(d) The practitioner will be given every reasonable opportunity to present his or her case.

8.5 The Capability Hearing

(a) During the hearing the panel and its advisers, the practitioner and their representative, and the case manager and their HR advisor will be present at all times. Witnesses will be admitted only when required to provide evidence and answer any questions. The Chairman of the panel will be responsible for the proper conduct of the proceedings.

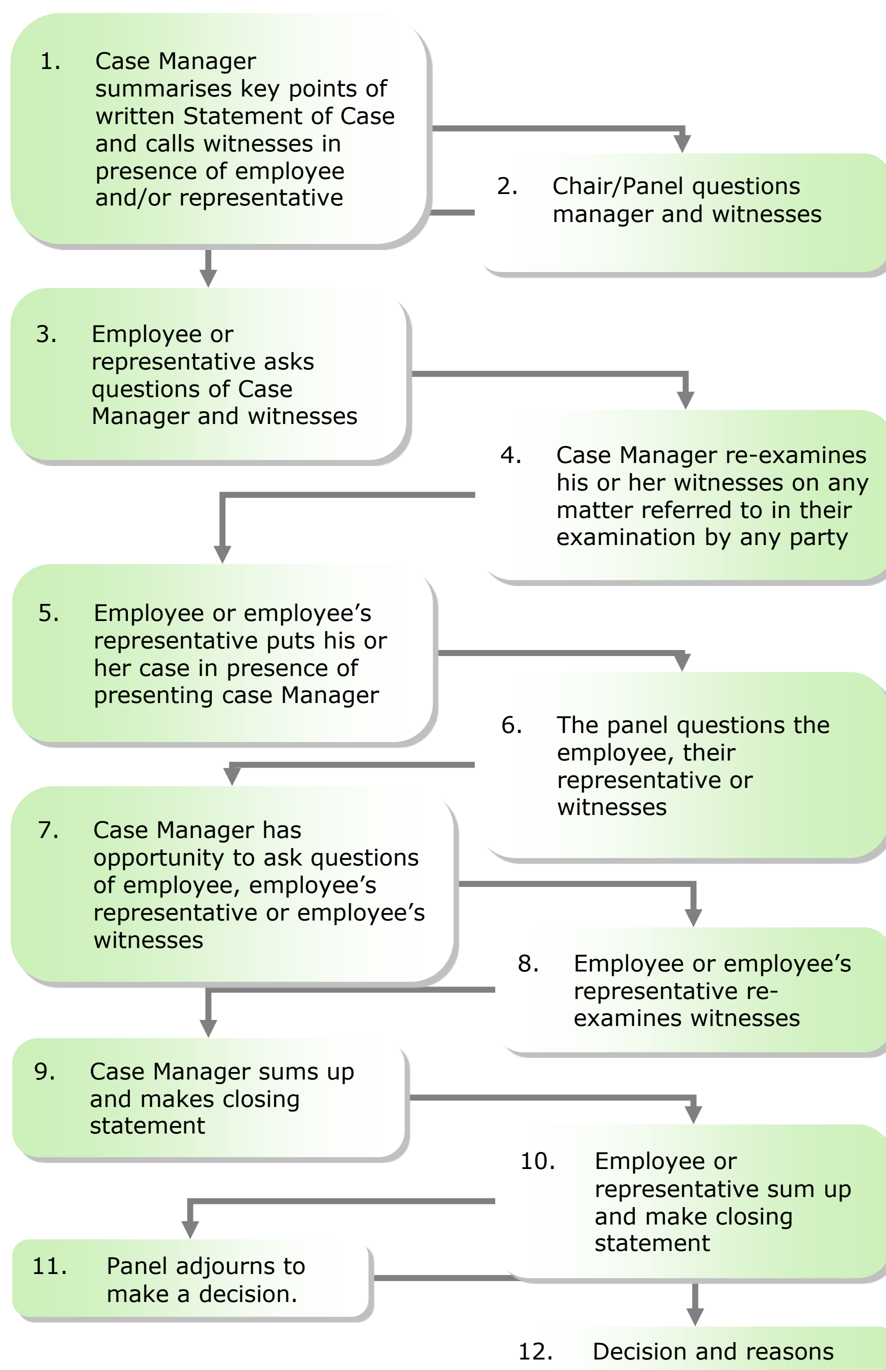
(b) The practitioner may be supported in the process by a friend, partner or spouse, colleague, trade union or professional association representative. Such a representative may be legally qualified but they will not be representing the practitioner formally in a legal capacity. The representative will be entitled to present a case on behalf of the practitioner, address the panel and question the management case and any witness evidence.

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

(d) The case manager will present the management case, which may include calling the case investigator as a witness as well as any other witnesses. The practitioner will then ask any questions followed by the panel. This will be followed by the practitioner presenting their case, and calling any witnesses. The case manager can ask any questions, followed by the panel.

(e) The case manager will then be invited to make a brief closing statement, summarising the key points of the case. The practitioner will then make a brief closing statement summarising the key points. The practitioner will be advised by the Chairman how and when they will be informed of the panel's decision. The panel shall then retire to consider its decision.

8.6 Capability hearing proceedings



8.7 Possible capability panel outcomes

(a) The panel will have the power to make the following decisions:

- No action required
- Verbal Warning : that there must be an improvement in performance/behaviour within a specified time scale with a written statement of what is required and how it might be achieved. This will remain on the practitioner's record for six months.

- First Written Warning: setting out the improvement in clinical performance/behaviour to be made within a specified time scale. This will remain on the practitioner's record for one year.
- Final Written Warning: setting out the improvement in clinical performance/behaviour to be made within a specified time scale. This will remain on the practitioner's record for one year.
- Dismissal: The decision must include the reason for the decision, the right of appeal and notification of any intent to make a referral to the GMC/GMD or any other external/professional body.

(b) Notification to the practitioner of any of the above sanctions must be confirmed in writing within seven calendar days of the capability hearing. A record of the outcome will be kept on the practitioner's personal file and should be removed following the specified period if no further action is taken.

8.8 Appeal against capability panel decision

(a) The practitioner has the right of appeal against all sanctions. The practitioner must appeal to the Director of Workforce and Organisational Development within 35 calendar days from the date of the letter confirming the outcome of the capability hearing.

(b) The purpose of the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision reached by the panel. The appeal panel has the power to confirm or vary the decision made at the capability hearing, or order that the case is reheard.

(c) The appeal panel should consist of three members who have not had any previous direct involvement in the case. These are the Trust Chairman or deputy, a medically or dentally qualified member who is not employed by the Trust, and an independent member (trained in legal aspects of appeals) from an approved pool, who will act as designated Chairman or suitable deputy. The appeal panel will be supported by a senior HR practitioner. The designated Board member cannot be involved. The appeal panel has the right to call witnesses on its own volition but must notify both parties at least 14 calendar days in advance of the hearing, and provide them with a written statement from any such witness at the same time.

(d) The appeal hearing should ordinarily be heard within 35 calendar days from the date of the appeal letter being received. The decision of the appeal panel should be confirmed in writing within 7 calendar days of concluding the appeal.

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

(f) After summing up by both parties, the appeal panel will make their decision in private. The decision of the appeal panel shall be made in writing and copied to the case manager within 7 calendar days of the conclusion of the hearing. The decision of the appeal panel is final and binding.

8.9 Review

(a) This policy will be reviewed every three years or in line with changes to legislation or best practice guidance.

8.10 Equality Impact Assessment (EIA) statement

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

9. References

9.1 NCAS The Back on Track framework for further training December 2010

9.2 NCAS Understanding performance difficulties in doctors November 2004

9.3 Maintaining high professional standards - November 2005

9.4 Working Together to Safeguard Children DCSF 2010

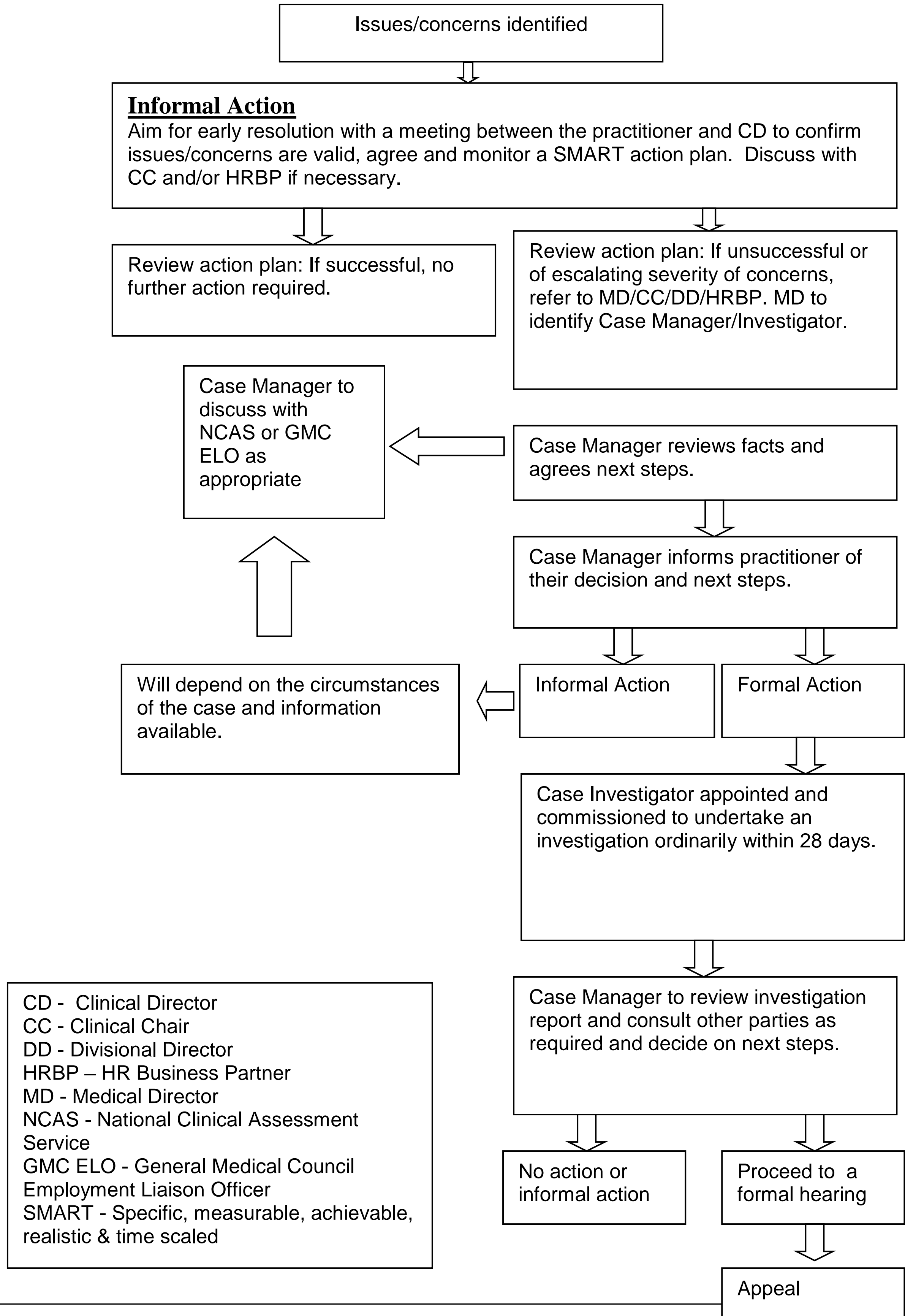
9.5 Assuring the quality of medical appraisal for revalidation RST 2009

9.6 Information Management & Quality Assurance RST December 2011

9.7 Equality Act 2010

10. Associated Documentation

10.1 Quick Reference Guide – Process Flowchart



10.2 Resources available for remediation

(a) Resolving performance concerns

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

(b) Remediation

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

(c) Rehabilitation

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

(d) Re-skilling

- Re-skilling is the process of addressing gaps in knowledge, skills and/or behaviours which result from an extended period of absence (usually over 6 months) so that the practitioner has the opportunity to return to safe practice. This may, for example, follow suspension, exclusion, maternity, carer or other statutory leave, career break or ill health (references: The Back on Track Framework for Further Training National Patient Safety Agency and National Clinical Assessment Service).

(e) Interventions

- A wide range of interventions will be available and a tailored action plan should be developed depending on individual need. The following may be useful to consider:
  - Case based reviews
  - Simulation tests
  - Supervised practice with immediate feedback
  - Videoing consultations with reflection and discussion
  - Tutorials
  - Workshops
  - Courses (internal or external)
  - Focused reading with reflective notes
  - Language/communication skills based activities
  - Behaviour coaching
  - Close monitoring of PDP via appraisal supervision process
  - Colleague and patient multi-source feedback

- Mentoring
- Protected learning and development time – this will need to be underpinned by clinical supervision and also professional supervision.
- Consideration of an out-placement for the practitioner
- Rehabilitation after ill health
- This may include features from the above list but also health monitoring, reasonable adjustments to the workplace or job plan, personal adjustments to the job plan/contract and counselling. Clinical supervision and professional supervision are also required.

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

- Reflective learning logs
- Certificates of CPD
- Meeting notes
- Multi-source feedback including from patients and colleagues
- Results of audits
- Professional development plans
- Compliments & cards
- Complaints
- Operating logs
- Morbidity and mortality data
- Feedback from work based assessments
- Case based reviews
- Mini CEX
- OSCEs
- Video recording of consultations
- Simulation
- Scenarios

(g) Out-placement

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

10.3 Process for Exclusion

(a) The term exclusion is used to differentiate from action by a regulatory authority who may suspend registration and is used whenever a practitioner is excluded from the workplace by the employer.

10.4 Use of 'Exclusion'

(a) 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 Chief Executive and the designated Board member.
- 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.

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

(c) Where the practitioner is a Clinical Academic employed by the University of Bristol, consultation will ordinarily take place with the Head of Department of the practitioner prior to any action taken under this section.

10.5 Purpose of 'Exclusion'

(a) The purpose of exclusion is to protect the interests of patients or 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.

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

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

10.6 Alternatives to exclusion

(a) Alternative ways to managing risks avoiding exclusion include:

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

10.7 Action plan feasibility

(a) In cases relating to the capability of a practitioner consideration should be given to whether an action plan to resolve the problem can be agreed with the practitioner. Advice on the practicality of this approach should be sought from NCAS.

(b) If the nature of the problem and a workable remedy cannot be determined in this way, the case manager will seek to agree with the practitioner to refer the case to NCAS which can assess the problem in more depth and give advice on any action necessary. NCAS can offer immediate telephone advice to case managers considering restriction of practice or exclusion and whether or not the practitioner is excluded, provide an analysis of the situation and offer advice to the case manager.

10.8 Key features of exclusion from work

(a) An initial "immediate" exclusion of no more than two weeks if warranted

(b) Notification of NCAS before formally excluding the practitioner

(c) Formal exclusion (if necessary) for periods up to four weeks

(d) Advice on the case management plan from NCAS

(e) Appointment of a designated Board member to monitor the exclusion.

(f) Referral to NCAS for formal assessment, if part of a case management plan

(g) Active review to decide renewal or cessation of exclusion

(h) Performance reporting on the management of the case

(i) Programme for return to work if not referred to disciplinary procedures or performance assessment.

10.9 Immediate exclusion

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

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

(b) Such exclusion will allow a more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to contact NCAS for advice and to convene a case conference as necessary. The senior manager making the exclusion must explain why the exclusion is being made in broad terms (there may be no formal allegation at this stage) and agree a date up to a maximum of two weeks by which the immediate exclusion will be reviewed and either lifted or confirmed.

10.10 Formal exclusion

(a) A formal exclusion may only take place after management has first considered whether there is a case to answer and then considered at a case conference, whether there is reasonable and proper cause to exclude. The Medical Director/Deputy Medical Director/Clinical Chair or Case Manager are

authorized to formally exclude the practitioner. NCAS must be consulted where formal exclusion is being considered.

(b) If a case investigator has been appointed he or she must produce a preliminary report as soon as is possible to be available for any case conference. This preliminary report is advisory to assist in determining next steps as considered appropriate.

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

- There is a concern about the practitioner's capability;
- The complexity of the case warrants further detailed investigation before advice can be given on the way forward;
- Formal exclusion of one or more clinicians must only be used where there is a need to protect the interests of patients or other staff pending the outcome of a full investigation of - allegations of misconduct; concerns about serious dysfunctions in the operation of a clinical service or concerns about lack of capability or poor performance of sufficient seriousness that it is warranted in order to protect patients; the presence of the practitioner in the workplace is likely to hinder the investigation.

(d) Full consideration should be given to whether the practitioner could continue in or (in cases of an immediate exclusion) return to work in a limited capacity or in an alternative, possibly non-clinical role, pending the resolution of the case.

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

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

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

(h) 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), NCAS may be consulted 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 "renewability" must be adhered to and any further exclusion be confirmed in writing to the practitioner.

(i) 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 formal exclusion and notify the designated board member as soon as is practicable.

(j) There are no other forms of exclusion other than those laid down in this procedure.

10.11 Exclusion from the premises

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

10.12 Keeping in contact

(a) Exclusion under this procedure will usually be on full pay. Therefore the practitioner must remain available for work with their employer during their normal contracted hours. The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager's consent to continuing to undertake such work or to take annual leave or study leave. The practitioner will be given 24 hours' notice to return to work. In exceptional circumstances the case manager may decide that payment is not justified because the practitioner is no longer available for work (e.g. travel abroad without agreement).

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

10.13 Informing other organisations

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

(b) Where the case manager believes that the practitioner is practising in other parts of the NHS or in the private sector in breach or defiance of an undertaking not to do so, he or she should contact the professional regulatory body.

10.14 Keeping exclusions under review – Informing the Board

(a) The Medical Director must inform the designated board member about exclusion at the earliest opportunity. The designated Board has a responsibility to ensure that the Trust's internal procedures are being followed. He/she should therefore:

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

10.15 Regular review

(a) The case manager must review the exclusion before the end of each four week period and report the outcome to the Medical Director and designated Board member. In the case of a Clinical Academic, the report should also be copied to the University Head of Department. This report is advisory and it would be for the case manager to decide on the next steps as appropriate. The exclusion should

usually be lifted and the practitioner allowed back to work, with or without conditions placed upon the employment, at any time if the original reasons for exclusion no longer apply and there are no other reasons for exclusion.

(b) It is important to recognise that Board members might be required to sit as members of a future disciplinary, capability or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of patients, other staff, the practitioner, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the practitioner returning to limited or alternative duties where practicable.

10.16 Return to work

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

11. Appendix A – Dissemination, Implementation and Training Plan

11.1 The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Richard Lewis, Associate Director of HR
This document replaces existing documentation:	Managing Capability Concerns of Medical & Dental
Existing documentation will be replaced by:	No other documentation to be replaced
This document is to be disseminated to:	All Medical & Dental Staff (available of HR Web)
Training is required:	N/A
The Training Lead is:	N/A

Additional Comments
[DITP - Additional Comments]

12. Appendix B – Document Checklist

12.1 The checklist set out in the following table confirms the status of 'diligence actions' required of the 'Document Owner' to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The 'Approval Authority' will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Title	The title is clear and unambiguous:	Managing Capability Concerns of Medical & Dental
	The document type is correct (i.e. Strategy, Policy, Protocol, Procedure, etc.):	Policy
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation (e.g. 'Personal Data' as defined in the Data Protection Act 2000):	Yes
	All terms used are explained in the 'Definitions' section:	Yes
	Acronyms are kept to the minimum possible:	Yes
	The 'target group' is clear and unambiguous:	Yes
	The 'purpose and scope' of the document is clear:	Yes
Document Owner	The 'Document Owner' is identified:	Richard Lewis, Associate Director of HR
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	TPF/ JUC / LNC
	The following were consulted:	Staffside (inc BMA)
	Suitable 'expert advice' has been sought where necessary:	Confirmed
Evidence Base	References are cited:	References cited
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	Trust Objectives
Equality	The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document:	Equality Impact Assessment completed
Monitoring	Monitoring provisions are defined:	Monitoring provisions are defined
	There is an audit plan to assess compliance with the provisions set out in this procedural document:	Audit confirmed

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
	The frequency of reviews, and the next review date are appropriate for this procedural document:	24 months
Approval	The correct 'Approval Authority' has been selected for this procedural document:	Approval Authority is appropriate

Additional Comments
[DCL - Additional Comments]