



**MAINTAINING HIGH PROFESSIONAL STANDARDS IN THE  
MODERN NHS**

# Maintaining High Professional Standards in the Modern NHS

## Introduction

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

- Part I: Action when a concern arises; and
- Part II: Restriction of practice and exclusion.

The Department has now agreed with the British Medical Association and British Dental Association the remaining three parts of the framework covering new disciplinary procedures for doctors and dentists employed in the NHS. These are:

- Part III: Conduct hearings and disciplinary matters;
- Part IV: Procedures for dealing with issues of capability; and
- Part V: Handling concerns about a practitioner's health.

As with Parts I and II, Parts III, IV, and V of the framework have been drafted in close collaboration with NHS Employers and the National Clinical Assessment Authority.

The new procedure replaces the current disciplinary procedures contained in circular HC(90)9, as well as the Special Professional Panels ("the three wise men) provided for in HC(82)13 and abolishes the right of appeal to the Secretary of State held by certain practitioners under Para 190 of the Terms and Conditions of Service. The Directions on Disciplinary Procedures 2005 require all NHS bodies in England to implement the framework within their local procedures by 1 June 2005. It has also been agreed with Monitor that the framework should be issued to NHS Foundation Trusts as advice.

## Key Changes

The key changes are that:

- the distinction between personal and professional misconduct is abolished. Doctors and dentists employed in the NHS will be disciplined for misconduct under the same locally based procedures as any other staff member;
- there is a single process for handling capability issues about the practitioners professional competence closely tied in with the work of the National Clinical Assessment Authority;
- Health issues are routinely dealt with through the occupational health service;
- The employing Trust is squarely responsible for the disciplining of its medical and dental staff – not outsiders;
- There is scope bring in expert advice for panels considering capability issues;
- The capability panel will be handled by an independent chair;
- The same disciplinary procedures will apply to all doctors and dentists employed in the NHS.

# Doctors' and dentists' disciplinary framework: introduction and explanatory note

NHS organisations are required to have procedures for handling concerns about the conduct, performance and health of medical and dental employees, (excluding those who perform PCT Medical Services for the exercise of those functions, as far as they are covered by the Primary Care List System). Under the Restriction of Practice and Exclusion from Work Directions 2003, and the Directions on Disciplinary Procedures 2004, these local procedures must be in accordance with the framework.

This framework has been developed at a national level by the Department of Health, the NHS Confederation, the British Medical Association and the British Dental Association and applies to the NHS in England. It covers:

- action to be taken when a concern about a doctor or dentist first arises;
- procedures for considering whether there need to be restrictions placed on a doctor or dentists practice or suspension is considered necessary
- guidance on conduct hearings and disciplinary procedures
- procedures for dealing with issues of capability
- arrangements for handling concerns about a practitioners health

## Background

1. For a number of years there has been concern about the way in which complaints about, and disciplinary action against, doctors and dentists have been handled in the NHS and particularly about the use of suspension\* in such cases. The National Clinical Assessment Authority (NCAA), which was established to improve arrangements for dealing with the poor clinical performance of doctors, has by working with the NHS helped to avoid the suspension, informal suspension and other authorised absences from work of 85% of the cases referred to it where suspension was being contemplated by the NHS Trust. The number of doctors and dentists who have been suspended from work for long periods is a cause for concern. Although the numbers are small the costs to the NHS are substantial.

\* The term exclusion from work is used in this document 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 the hearing.

**Table 1. Number of doctors and dentists suspended for six months or more.**

Quarter	2000	2001	2002	2003
1.	33	32	30	27
2.	30	33	33	26
3.	26	33	38	32
4.	27	29	29	24

Changes to NHS disciplinary procedures are necessary as a result of the introduction of Shifting the Balance of Power, the Employment Act 2002 and the Follett report ("A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties" A report to the Secretary of State for Education and Skills, by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001).

2. Developing new arrangements for handling issues about medical and dental staff performance has become increasingly important both to tackle these concerns and to reflect the new systems for quality assurance and quality improvement which have been introduced in the NHS in recent years.

3. The new approach set out in the framework builds on four key elements:

- appraisal\* and revalidation - processes which encourage practitioners to maintain the skills and knowledge needed for their work through continuing professional development;  
\*Appraisal is a structured process which gives doctors an opportunity to reflect on their practice and discuss, with a suitably trained and qualified appraiser, any issues arising from their work, and their development needs. Appraisal is a contractual requirement for NHS consultants and GP Principals.
- the advisory and assessment services of the NCAA - aimed at enabling NHS Trusts to handle cases quickly and fairly reducing the need to use disciplinary procedures to resolve problems;
- tackling the blame culture - recognising that most failures in standards of care are caused by systems' weaknesses not individuals per se;

- abandoning the "suspension culture" - by introducing the new arrangements for handling exclusion from work set out in part II of this framework.

4. But to work effectively these need to be supported by a culture and by attitudes and working practices which emphasise the importance of doctors and dentists keeping their skills and knowledge up to date; maintaining their competence; and which support an open approach to reporting and tackling concerns about doctors' and dentists' practice. The new approach recognises the importance of seeking to tackle performance issues through training or other remedial action rather than solely through disciplinary action. However it is not intended to weaken accountability or avoid disciplinary action where there is genuinely serious misconduct.

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## **I. ACTION WHEN A CONCERN ARISES**

### **INTRODUCTION**

1. The management of performance is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to disciplinary procedures.

Concerns about a doctor or dentist's conduct or capability can come to light in a wide variety of ways, for example:

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

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

### **FRAMEWORK FOR NHS PROCEDURES**

3. All NHS bodies\* must have procedures for handling serious concerns about an individual's conduct and capability\*\*. These procedures must reflect the framework in this document and allow for informal resolution of less serious problems. Concerns about the capability of doctors and dentists in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.

\*In the Direction and the framework "NHS bodies" means: Strategic Health Authorities, Special Health Authorities, NHS Trusts and Primary Care Trusts.

\*\*A serious concern about capability will arise where the practitioner's actions have or may adversely affect patient care.

4. All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. The Chairman of the

Board must designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained. All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director\* will need to work with the Director/Head of HR to decide the appropriate course of action in each case. The Medical Director will act as the case manager in cases involving clinical directors and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases. The Medical Director is responsible for appointing a case investigator. \*\*In bodies that do not have a Medical Director, the Chief Executive should designate a senior clinical manager to perform the role assigned to the Medical Director in these procedures and ensure that they are appropriately trained.

### **Protecting the public**

5. When serious concerns are raised about a practitioner, the employer must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Part II of this framework sets out the procedures for this action.

6. The duty to protect patients is paramount. At any point in the process where the case manager has reached the clear judgement that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the regulatory body, whether or not the case has been referred to the NCAA\*. Consideration should also be given to whether the issue of an alert letter should be requested. \*The GMC or GDC will discuss with the NCAA whether any immediate action is needed by the GMC/GDC or whether the NCAA's consideration should continue.

### **Involving the NCAA**

7. At any stage of the handling of a case consideration should be given to the involvement of the NCAA. The NCAA has developed a staged approach to the services it provides NHS Trusts and practitioners. This involves:

- Immediate telephone advice, available 24 hours
- Advice, then detailed supported local case management
- Advice, then supported local clinical performance assessment
- Advice, then detailed NCAA clinical performance assessment
- Support with implementation of recommendations arising from assessment
- Understanding the issue and investigation

## **SUMMARY OF KEY ACTION:**

- Clarify what has happened and the nature of the problem or concern;
- Discuss with the NCAA what the way forward should be;
- Consider whether restriction of practice or exclusion is required;
- If a formal approach under the conduct or capability procedures is required, appoint an investigator;
- If the case can be progressed by mutual agreement consider whether an NCAA assessment would help clarify the underlying factors that led to the concerns and assist with identifying the solution.

8. The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures. This is a difficult decision and should not be taken alone but in consultation with the Director/Head of HR and the Medical Director and the National Clinical Assessment Authority (NCAA). The NCAA can provide a sounding board for the case manager's first thoughts. However, the NCAA asks that the first approach to them should be made by the NHS body's Chief Executive or Medical Director. Where there are concerns about a doctor or dentist in training, the postgraduate dean should be involved as soon as possible.

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

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

11. Where it is decided that a more formal route needs to be followed (perhaps leading to conduct or capability proceedings) the Medical Director must, after discussion between the Chief Executive and Director/Head of Human Resources, appoint an appropriately experienced or trained person as case investigator. The seniority of the case investigator will differ depending

on the grade of practitioner involved in the allegation. Several clinical managers should be appropriately trained, to enable them to carry out this role when required.

12. The case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings. The case investigator:

- must formally involve a senior member of the medical or dental staff\* where a question of clinical judgement is raised during the investigation process.  
\*Where no other suitable senior doctor or dentist is employed by the NHS body a senior doctor or dentist from another NHS body should be involved.
- must ensure that safeguards are in place throughout the investigation so that breaches of confidentiality are avoided as far as possible. Patient confidentiality needs to be maintained but the disciplinary panel will need to know the details of the allegations. It is the responsibility of the case investigator to judge what information needs to be gathered and how - within the boundaries of the law - that information should be gathered.
- must ensure that there are sufficient written statements collected to establish a case prior to a decision to convene a disciplinary panel, and on aspects of the case not covered by a written statement, ensure that oral evidence is given sufficient weight in the investigation report.
- must ensure that a written record is kept of the investigation, the conclusions reached and the course of action agreed by the Director or Head of HR with the Medical Director.
- must assist the designated Board member in reviewing the progress of the case.

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

13. The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided, that an investigation is to be undertaken, the name of the case investigator and made aware of the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that 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.

14. At any stage of this process - or subsequent disciplinary action - the practitioner may be accompanied in any interview or hearing by a companion. In addition to statutory rights under the Employment Act 1999, the companion may be another employee of the NHS body; an official or lay representative of the British Medical Association, British Dental Association or defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity.

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

16. 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.

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

- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the NHS body's occupational health service;
- there are concerns about the practitioner's performance that should be further explored by the National Clinical Assessment Authority;
- restrictions on practice or exclusion from work should be considered;
- there are serious concerns that should be referred to the GMC or GDC;
- there are intractable problems and the matter should be put before a capability panel;
- No further action is needed.

## **Involvement of the NCAA following local investigation**

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

19. The focus of the NCAA's work is therefore likely to involve performance difficulties which are serious and/or repetitive. That means:

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

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

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

20. Where an employing body is considering excluding a doctor or dentist whether or not his or her performance is under discussion with the NCAA, it is important for the NCAA to know of this at an early stage, so that alternatives to exclusion can be considered. Procedures for exclusion are covered in part II of the framework. It is particularly desirable to find an alternative when the NCAA is likely to be involved, because it is much more difficult to assess a doctor who is excluded from practice than one who is working.

21. A practitioner undergoing assessment by the NCAA must cooperate with any request to give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the NCAA assessment is complete\*. The NCAA has issued guidance on its processes, and how to make such referrals. This can be found at [www.ncaa.nhs.uk/services](http://www.ncaa.nhs.uk/services).

\*Under circular HSC 2002/011, Annex 1, paragraph 3, "A doctor undergoing assessment by the NCAA must give a binding undertaking not to practise in the NHS or private sector other than in their main place of NHS employment until the assessment process is complete."

22. Failure to co-operate with a referral to the NCAA may be seen as evidence of a lack of willingness on the part of the doctor or dentist to work with the employer on resolving performance difficulties. If the practitioner chooses not to co-operate with such a referral, that may limit the options open to the

parties and may necessitate disciplinary action and consideration of referral to the GMC or GDC.

### **Confidentiality**

23. Employers must maintain confidentiality at all times. No press notice should be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. The Employer should only confirm that an investigation or disciplinary hearing is underway.

24. Personal data released to the case investigator for the purposes of the investigation must be fit for the purpose, nor disproportionate to the seriousness of the matter under investigation. Employers should be familiar with the guiding principles of the Data Protection Act.

### **Transitional arrangements**

25. At the time of the implementation of this framework, a case manager must be appointed for all existing cases and the new procedures followed as far as is practical taking into account the stage the case has reached.

26. Where, in the view of the employer, an existing case could not be effectively resolved using this framework and a disciplinary process began before the Directions came into force, an alternative process may be used.

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## **Restriction of practice and exclusion from work**

### **Introduction**

1. This part of the framework replaces the guidance in HSG (94)49\*. Under the Restriction of Practice and Exclusion from Work Directions 2003 ("the directions"), NHS employers must incorporate these principles and procedures within their local procedures.

\*HSG(94)49- Disciplinary Procedures for Hospital and Community Medical and Hospital Dental Staff. Department of Health, 1994.

2. 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 the fitness to practise hearing.

3. The Direction requires that NHS bodies 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 Board;
- a detailed report is provided when requested to a single non-executive member of the Board (the "Designated Board Member") who will be responsible for monitoring the situation until the exclusion has been lifted.

### **Managing the risk to patients**

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

5. 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 ("suspension") should be reserved for only the most exceptional circumstances.

6. The purpose of exclusion is:

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

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

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

- Medical or clinical director 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.

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

## **THE EXCLUSION PROCESS**

9. Under the Direction, a NHS body 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.

### **Key features of Exclusion from Work**

- **An initial "immediate" exclusion of no more than two weeks if warranted;**
- **Notification of the NCAA before formal exclusion;**
- **Formal exclusion (if necessary) for periods up to four weeks;**
- **Advice on the case management plan from the NCAA;**
- **Appointment of a Board member to monitor the exclusion and subsequent action;**
- **Referral to NCAA for formal assessment, if part of case management plan;**
- **Active review 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 performance assessment.**

### **Roles of officers**

10. The Chief Executive of the employing organisation has overall responsibility for managing exclusion procedures and for ensuring that cases are properly managed. The decision to exclude a practitioner must be taken only by persons nominated under paragraph 12. The case should be discussed fully with the Chief Executive, the Medical Director, the Director/Head of Human Resources, the NCAA and other interested parties (such as the police where there are serious criminal allegations or the Counter Fraud & Security Management Service) prior to the decision to exclude a practitioner. In the rare cases where immediate exclusion is required, the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

11. The authority to exclude a member of staff must be vested in a nominated manager or managers of the NHS body. 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 Chief Executive, Medical Director and the Clinical Directors for staff below the grade of consultant.

12. The Medical Director will act as the case manager or delegate this role to a senior manager to oversee the case and appoint a case investigator to explore and report on the circumstances that have led to the need to exclude the staff member. The investigating officer will provide factual information to assist the case manager in reviewing the need for exclusion and making reports on progress to the Chief Executive or designated Board member.

## **Role of designated Board member**

13. Representations may be made to the designated Board member in regard to exclusion, or investigation of a case if these are not provided for by the NHS body's grievance procedures. The designated Board member must also ensure, among other matters, that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights (which, broadly speaking, sets out the framework of the rights to a fair trial).

## **Immediate exclusion**

14. An immediate time limited exclusion may be necessary for the purposes identified in paragraph 6 above following:

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

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

## **Formal exclusion**

15. A formal exclusion may only take place after the case manager has first considered whether there is a case to answer and then considered, at a case conference, whether there is reasonable and proper cause to exclude. The NCAA 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.

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

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

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

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

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

or

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

18. 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.

19. 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 state their case and propose alternatives to exclusion (e.g. further training, referral to occupational health, referral to the NCAA with voluntary restriction).

20. 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 (e.g. exclusion from the premises, see paragraph 23, and the need to remain available for work paragraph 24) 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.

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

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

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

### **Exclusion from premises**

24. 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. The practitioner may want to retain contact with colleagues, take part in clinical audit and to remain up to date with developments in their field of practice or to undertake research or training.

### **Keeping in contact and availability for work**

25. As exclusion under this framework should usually be on full pay, 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 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).

26. 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 (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.

## **Informing other organisations**

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

\*NHS bodies 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 honorary contracts. A draft model protocol is available from the Department of Health.

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

## **Informal exclusion**

29. No practitioner should be excluded from work other than through this new procedure. Informal exclusions, so called 'gardening leave' have been commonly used in the recent past. No NHS body may use "gardening leave" as a means of resolving a problem covered by this framework.

## **Existing suspensions & transitional arrangements**

30. At the time of 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.

31. A case manager should be appointed for each existing case and a review conducted of the need for the suspension as in paragraph 33 below. In cases where exclusion is considered to be necessary, the new system will apply and the exclusion will be covered by the four-week review rule set out below. The new exclusion will run for four weeks in the first instance.

## **KEEPING EXCLUSIONS UNDER REVIEW**

### **Informing the Board**

32. 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. It 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;
- receive a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed and extended. A copy must be sent to the Strategic Health Authority.

### **Regular review**

33. The case manager must review the exclusion before the end of each four week period and report the outcome to the Chief Executive and the Board\*. 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 the original reasons for exclusion no longer apply and there are no other reasons for exclusion. The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

\*It is important to recognise that Board members might be required to sit as members of a future disciplinary or appeal panel. Therefore, information to the Board should only be sufficient to enable the Board to satisfy itself that the procedures are being followed. Only the designated Board member should be involved to any significant degree in each review. Careful consideration must be given as to whether the interests of 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.

34. The NHS body must take review action before the end of each 4-week period. After three exclusions, the NCAA must be called in. The table below outlines the various activities that must be undertaken at different stages of exclusion.

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

Before the end of each exclusion (of up to 4 weeks) the case manager reviews the position.

- The case manager decides on next steps as appropriate. Further renewal may be for up to 4 weeks at a time.

- Case manager submits advisory report of outcome to Chief Executive and the Board.
- Each renewal is a formal matter and must be documented as such.
- The practitioner must be sent written notification on each occasion.
- Third review

If the practitioner has been excluded for three periods:

- A report must be made to the Chief Executive: outlining the reasons for the continued exclusion and why restrictions on practice would not be an appropriate alternative; and if the investigation has not been completed a timetable for completion of the investigation.
- The CE must report to the Strategic Health Authority (SHA) (see paragraphs 36-38 below) and the designate Board member (see paragraphs 41-42 below).
- The case must formally be referred to the National Clinical Assessment Authority (NCAA) explaining:
  - Why continued exclusion is appropriate
  - What steps are being taken to conclude the exclusion at the earliest opportunity
- The NCAA will review the case with the SHA and advise the NHS body on the handling of the case until it is concluded.

### **6 months review**

If the exclusion has been extended over six months,

- A further position report must be made by the Chief Executive to the SHA indicating:
  - the reason for continuing the exclusion;
  - anticipated time scale for completing the process;
  - actual and anticipated costs of the exclusion.
- The SHA will form a view as to whether the case is proceeding at an appropriate pace and in the most effective manner and whether there is any advice they can offer to the Board.

35. 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 NCAA should actively review those cases at least every six months.

## **The role of the SHA in monitoring exclusions**

36. When the SHA is notified of an exclusion, it should ensure that the NCAA has also been notified.

37. When an exclusion decision has been extended twice, the Chief Executive of the employing organisation (or a nominated officer) must inform the SHA of what action is proposed to resolve the situation. This should include dates for hearings or give reasons for the delay. Where retraining or other rehabilitation action is proposed, the reason for continued exclusion must be given.

38. The SHA will receive the monthly statistical summary given to Boards and collate them into a single report for the Department of Health.

## **The role of the Board and designated member**

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

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

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

42. This member's responsibilities include:

- receiving reports and reviewing the continued exclusion from work of the practitioner;
- considering any representations from the practitioner about his or her exclusion;
- considering any representations about the investigation;

## **RETURN TO WORK**

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

# **Maintaining High Professional Standards in the Modern NHS**

## ***III Conduct hearings and disciplinary matters***

### **Contents**

**Introduction**

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## **Maintaining High Professional Standards in the Modern NHS**

### **III. GUIDANCE ON CONDUCT HEARINGS AND DISCIPLINARY PROCEDURES**

#### **INTRODUCTION**

1. Misconduct matters for doctors and dentists, as for all other staff groups, are matters for local employers and must be resolved locally. All issues regarding the misconduct of doctors and dentists should be dealt with under the employer's procedures covering other staff charged with similar matters. Employers are nevertheless strongly advised to seek advice from the NCAA in conduct cases, particularly in cases of professional conduct.
2. Where the alleged misconduct relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the case investigator must obtain appropriate independent professional advice. Similarly where a case involving issues of professional conduct proceeds to a hearing under the employer's conduct procedures 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.<sup>1</sup>
3. NHS bodies 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 honorary contracts.

#### **Codes of Conduct**

4. Every NHS employer will have a Code of Conduct or staff rules which should set out acceptable standards of conduct and behaviour expected of all its employees. Breaches of these rules 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:

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<sup>1</sup> Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the medical staff committee or local negotiating committee

- A refusal to comply with reasonable requirements of the employer.
- An infringement of the employer's disciplinary rules including conduct that contravenes the standard of professional behaviour required by doctors and dentists by their regulatory body<sup>2</sup>.
- 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.

5. Examples of misconduct will vary greatly. The employer's Code of Conduct should set 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. Similarly the ACAS Code of Practice provides a non-exhaustive list of examples. 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.
6. Any allegation of misconduct against a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor with close involvement of the postgraduate dean from the outset.
7. 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.
8. Each case must be investigated, but as a general rule no employee should be dismissed for a first offence, unless it is one of gross misconduct.
9. It is for the employer to decide upon the most appropriate way forward, having consulted the NCAA and their own employment law specialist. 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
10. Many smaller organisations such as Primary Care Trusts, may not have all the necessary personnel in place to follow the procedures outlined in this

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<sup>2</sup> In case of doctors, *Good Medical Practice*. In the case of dentists, *Maintaining Standards*.

document. For example, some PCTs may not employ a medical director or may not employ medical or dental staff of sufficient seniority or from the appropriate specialty. Also, it may be difficult to provide senior staff to undertake hearings who have not been involved in the investigation.

11. Such organisations should consider working in collaboration with other local NHS organisations (eg other PCTs or larger employers) in order to provide sufficient personnel to follow the procedures described. The organisation should be sufficiently distant to avoid any organisational conflict of interest and any nominee should be asked to declare any conflict of interest. In such circumstances the NHS organisation should contact the NCAA to take its advice on the process followed and ensure that it is in accordance with the policy and procedure set out in this document.

## **ALLEGATIONS OF CRIMINAL ACTS**

### **Action when investigations identify possible criminal acts**

12. 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 which 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 & Security Management Service must be contacted.

### **Cases where criminal charges are brought not connected with an investigation by an NHS employer**

13. 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 consider whether the employee poses a risk to patients or colleagues and whether their conduct warrants instigating an investigation and the exclusion of the practitioner. The employer will have to give serious consideration to whether the employee can continue in their job once criminal charges have been made. Bearing in mind the presumption of innocence, the 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 job, should be allocated to other duties or should be excluded from work. This will depend on the nature of the offence and advice should be sought from an HR or legal adviser. Employers should as a matter of good practice explain the reasons for taking such action.

## **Dropping of charges or no court conviction**

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

## **GUIDANCE ON AGREEING TERMS FOR SETTLEMENT ON TERMINATION OF EMPLOYMENT**

15. In some circumstances, terms of settlement may be agreed with a doctor or dentist if their employment is to be terminated. The following good practice principles are set out as guidance for the Trust:

- Settlement agreements must not be to the detriment of patient safety.
- It is not acceptable to agree any settlement that precludes either appropriate investigations being carried out and reports made or referral to the appropriate regulatory body.
- Payment will not normally be made when a member of staff's employment is terminated on disciplinary grounds or following the resignation of the member of staff.
- Expenditure on termination payments must represent value for money. For example, the Trust should be able to defend the settlement on the basis that it could conclude the matter at less cost than other options. A clear record must be kept, setting out the calculations, assumptions and rationale of all decisions taken, to show that the Trust or authority has taken into account all relevant factors, including legal advice. The audit trail must also show that the matter has been considered and approved by the remuneration committee and the Board. It must also be able to stand up to district auditor and public scrutiny.
- Offers of compensation, as an inducement to secure the voluntary resignation of an individual, must not be used as an alternative to the disciplinary process.

- All job references must be accurate, realistic and comprehensive and under no circumstance may they be misleading.
- Where a termination settlement is agreed, details may be confirmed in a Deed of Compromise that should set out what each party may say in public or write about the settlement. The Deed of Compromise is for the protection of each party, but it must not include clauses intended to cover up inappropriate behaviour or inadequate services and should not include the provision of an open reference.<sup>3</sup>

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<sup>3</sup> For the purposes of this paragraph, an open reference is one that is prepared in advance of a request by a prospective employer.

# Maintaining High Professional Standards in the Modern NHS

## *IV Procedures for dealing with issues of capability*

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## Maintaining High Professional Standards in the Modern NHS

### IV. PROCEDURES FOR DEALING WITH ISSUES OF CAPABILITY

#### INTRODUCTION & GENERAL PRINCIPLES

1. 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 organisational failures, or demonstrate that they are untoward outcomes which could not have been predicted and are not the result of any individual or systems failure. Each will require appropriate investigation and remedial actions.
2. The National Patient Safety Agency (NPSA) was established to co-ordinate the efforts of all those involved in healthcare to learn from adverse incidents occurring within the NHS. In particular, the NPSA aims to facilitate the development of an open and fair culture, which encourages doctors, dentists and other NHS staff to report adverse incidents and other near misses in a climate free from fear of personal reprimand, where the sharing of experience helps others to learn lessons and in turn improve patient safety.
3. However, there will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues. Matters that should be described and dealt with as misconduct issues are covered in part III of this framework.
4. Concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. Advice from the National Clinical Assessment Authority (NCAA)<sup>4</sup> will help the Trust to come to a decision on whether the matter raises questions about the practitioner's capability as an individual (health problems, behavioural difficulties or lack of clinical competence) or whether there are other matters that need to be addressed. If the concerns about capability cannot be resolved routinely by management, **the matter must be referred to the NCAA before the matter can be considered by a capability panel** (unless the practitioner refuses to have his or her case referred). Employers are also strongly advised to involve the NCAA in all other cases particularly those involving professional conduct.

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<sup>4</sup> or successor body

5. Matters which may fall under the capability procedures include:

**Some examples of concerns about capability**

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

6. Wherever possible, employers should aim to resolve issues of capability (including clinical competence and health) through ongoing assessment and support. Early identification of problems is essential to reduce the risk of serious harm to patients. The NCAA has a key role in providing expert advice and support for local action to support the remediation of a doctor or dentist and should be consulted. A web based toolkit has been developed and is available at: [www.ncaa.nhs.uk/toolkit](http://www.ncaa.nhs.uk/toolkit)
7. Any concerns about capability relating to a doctor or dentist in recognised training grades should be considered initially as a training issue and dealt with via the educational supervisor and college or clinical tutor, with close involvement of the postgraduate dean from the outset.

**How to proceed where conduct and capability issues involved**

8. It is inevitable that some cases will cover conduct and capability issues. It is recognised that these cases can be complex and difficult to manage. If a case covers more than one category of problem, they should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately. It is for the employer to decide on the most appropriate way forward having consulted with an NCAA adviser and their own employment law specialist.

**Duties of Employers**

9. The procedures set out below are designed to cover issues where a doctor's or dentist's *capability* to practise is in question<sup>5</sup>. Prior to instigating these procedures, the employer should consider the scope for resolving the issue through counselling or retraining and should take advice from the NCAA.

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<sup>5</sup> see paragraph 3 in Part III concerning clinical academics and paragraphs 9 and 10 in Part III on arrangements for small organisations.

10. Capability may be affected by ill health. Arrangements for handling concerns about a practitioner's health are described in part V of this framework. Employers must follow their own procedure for dealing with ill health – including obtaining advice, usually from a consultant Occupational Health Physician.
11. Employers must ensure that investigations and capability procedures are conducted in a way that does not discriminate on the grounds of race, gender, disability or indeed on other grounds.
12. Employers must ensure that managers and case investigators receive appropriate and effective training in the operation of capability procedures. Those undertaking investigations or sitting on capability or appeals panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members must have completed before they can take a part in these proceedings.

## **CAPABILITY PROCEDURE**

### **The pre-hearing process**

13. When a report of the Trust investigation (as in Part I<sup>6</sup>) has been received, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator. Comments in writing from the practitioner, including any mitigation, must normally be submitted to the case manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances, for example in complex cases or due to annual leave, the deadline for comments from the practitioner should be extended.
14. The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAA. The case manager will need to consider urgently:
  - whether action under Part II of the framework is necessary to exclude the practitioner; or
  - to place temporary restrictions on their clinical duties.

The case manager will also need to consider with the Medical Director and head of Human Resources whether the issues of capability can be

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<sup>6</sup> "Action when a concern arises" - Part I of the framework issued under the Restriction of Practise & Exclusion from Work Directions 2003.

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

15. The NCAA will assist the employer to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by the NCAA, 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 NCAA advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.
16. If the practitioner does not agree to the case being referred to the NCAA, a panel hearing will normally be necessary.
17. The following procedure should be followed before the hearing:

### ***Procedure to be followed prior to capability hearings***

- The case manager must notify the practitioner in writing of the decision to arrange a capability hearing. This notification should be made at least 20 working days before the hearing and include details of the allegations and the arrangements for proceeding including the practitioner's rights to be accompanied and copies of any documentation and/or evidence that will be made available to the capability panel. This period will give the practitioner sufficient notice to allow them to arrange for a companion to accompany them to the hearing if they so choose.
- All parties must exchange any documentation, including witness statements, on which they wish to rely in the proceedings no later than 10 working days before the hearing. In the event of late evidence being presented, the employer should consider whether a new date should be set for the hearing.
- Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days), to proceed with the hearing in the practitioner's absence, although the employer should act reasonably in deciding to do so.
- Should the practitioner's ill health prevent the hearing taking place the employer should implement their usual absence procedures and involve the Occupational Health Department as necessary.
- Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the capability hearing. Following representations from either side contesting a witness statement which is to be relied upon in the hearing, the Chairman 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 required to attend the hearing choose to be accompanied, the person accompanying them will not be able to participate in the hearing.

## The hearing framework

18. The capability 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 a medical or dental practitioner who is not employed by the Trust.<sup>7</sup> As far as is reasonably possible or practical, no member of the panel or advisers to the panel should have been previously involved in the investigation. In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.
19. Arrangements must be made for the panel to be advised by:

- A senior member of staff from Human Resources, and
- A senior clinician from the same or similar clinical specialty as the practitioner concerned, but from another NHS employer.
- A representative of a university if provided for in any protocol as mentioned in paragraph 18.

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

20. 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.

## Representation at capability hearings

21. 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.

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<sup>7</sup> Employers are advised to discuss the selection of the medical or dental panel member with the appropriate local professional representative body eg for doctors in a hospital trust the medical staff committee or local negotiating committee.

22. The practitioner may be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not, 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.

### **Conduct of the capability hearing**

23. The hearing should be conducted as follows:

- The panel and its advisers (see paragraph 19), 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:

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| <ul style="list-style-type: none"><li>• The witness to confirm any written statement and give any supplementary evidence.</li><li>• The side calling the witness can question the witness.</li><li>• The other side can then question the witness.</li><li>• The panel may question the witness.</li><li>• 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.</li></ul> |
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**The order of presentation shall be:**

- The Case Manager presents the management case including calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.
- The Chairman shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.
- The practitioner and/or their representative shall present the practitioner's case, calling any witnesses. The above procedure for dealing with witnesses shall be undertaken for each witness in turn, at the end of which each witness shall be allowed to leave.
- The Chairman shall invite the practitioner and/or representative to clarify any matters arising from the practitioner's case on which the panel requires further clarification.
- The Chairman shall invite the Case Manager to make a brief closing statement summarising the key points of the case.
- The Chairman shall invite the practitioner and/or representative to make a brief closing statement summarising the key points of the practitioner's case. Where appropriate this statement may also introduce any grounds for mitigation.
- The panel shall then retire to consider its decision.

## Decisions

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

### ***Possible decisions made by the capability panel***

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

It is also reasonable for the panel to make comments and recommendations on issues other than the competence of the practitioner, where these issues are relevant to the case. For example, there may be matters around the systems and procedures operated by the employer that the panel wishes to comment upon.

25. A record of oral agreements and written warnings should be kept on the practitioner's personnel file but should be removed following the specified period.

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

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

## **APPEALS PROCEDURES IN CAPABILITY CASES**

### **Introduction**

28. Given the significance of the decision of a capability panel to warn or dismiss a practitioner, it is important that a robust appeal procedure is in place. Every Trust must therefore establish an internal appeal process for appeal against decisions of a capability panel. There is no requirement for Trusts to set up a procedure for appeal against exclusion or investigation as these are adjuncts to the stages of the decision making process on what future action to take. The procedure for handling issues about the classification of a case as misconduct is dealt with in paragraph 9 of Part III of this framework.
29. The appeals procedure provides a mechanism for practitioners who disagree with the outcome of a decision to have an opportunity for the case to be reviewed. The appeal panel will need to establish whether the Trust's procedures have been adhered to and that the panel in arriving at their decision acted fairly and reasonably based on:

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

It can also hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel, however, should not rehear the entire case (see paragraph 31 below).

30. A dismissed practitioner will in all cases be potentially able to take their case to an Employment Tribunal where the reasonableness or otherwise of the Trust's actions will be tested.

### **The appeal process**

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

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

### **The appeal panel**

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

#### **Membership of the appeal panel**

- An independent member (trained in legal aspects of appeals) from an approved pool.<sup>8</sup> 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<sup>9</sup> who must also have the appropriate training for hearing an appeal.
- In the case of clinical academics a further panel member may be appointed in accordance with any protocol agreed between the employer and the university.

34. 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 NHS employer.<sup>10</sup>
- A Senior Human Resources specialist.

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<sup>8</sup> See Annex A.

<sup>9</sup> Employers are advised to discuss the selection of the medical or dental panel member with the local professional representative body eg in a hospital trust the medical staff committee or local negotiating committee.

<sup>10</sup> Where the case involves a dentist this may be a consultant or an appropriate senior practitioner.

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

35. The Trust should arrange the panel and notify the appellant as soon as possible and in any event within the recommended timetable in paragraph 34. 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. Trusts are reminded of the need to act reasonably at all stages of the process.
36. It is in the interests of all concerned that appeals are heard speedily and as soon as possible after the original capability hearing. The following timetable should apply in all cases:

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

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

### **Powers of the appeal panel**

38. 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.
39. 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.

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

### **Conduct of appeal hearing**

41. All parties should have all documents, including witness statements, from the previous capability hearing together with any new evidence.
42. The practitioner may be represented in the process by a friend, partner or spouse, colleague or a representative who may be from or retained by a trade union or defence organisation. Such a representative may be legally qualified but they will not, 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.
43. 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.
44. The panel, after receiving the views of both parties, shall consider and make its decision in private.

### **Decision**

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

### **Action following hearing**

46. Records must be kept, including a report detailing the capability issues, the practitioner's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with the capability procedure and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon

them, such as the practitioner, the Regulatory Body, or in response to a Direction from an Employment Tribunal.

## **TERMINATION OF EMPLOYMENT WITH PERFORMANCE ISSUE UNRESOLVED**

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

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

49. If an excluded employee or an employee facing capability proceedings becomes ill, they should be subject to the employer's usual sickness absence procedures. The sickness absence procedures take precedence over the capability procedures and the employer should take reasonable steps to give the employee time to recover and attend any hearing. Where the employee's illness exceeds 4 weeks, they must be referred to the Occupational Health Service. The Occupational Health Service will advise the employer on the expected duration of the illness and any consequences it may have for the capability process and will also be able to advise on the employee's capacity for future work, as a result of which the employer may wish to consider retirement on health grounds. Should the employment be terminated as a result of ill health, the investigation should still be taken to a conclusion and the employer form a judgement as to whether the allegations are upheld.

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

51. Where a case involves allegations of abuse against a child, the guidance issued to the NHS in September 2000, called "The Protection of Children Act 1999 – A Practical Guide to the Act for all Organisations Working with Children" gives more detailed information. A copy can be found on the Department of Health website<sup>11</sup>.

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<sup>11</sup> [\*A Practical Guide to the Act for all Organisations Working with Children\*](#)

# Maintaining High Professional Standards in the Modern NHS

## Appeal Panels in Capability Cases

## Annex A

### Introduction

1. The framework provides for the appeal panel to be chaired by an independent member from an approved pool trained in legal aspects of appeals.
2. It has been agreed that it would be preferable to continue to appoint appeal panel chairmen through a separately held national list rather than through local selection. The benefits include:
  - the ability to secure consistency of approach through national appointment, selection and training of panel chairmen; and
  - the ability to monitor performance and assure the quality of panellists.
3. The following provides an outline of how it is envisaged that the process will work.

### Creating and administering the list

4. The responsibility for recruitment and selection of panel chairs to the list will lie with *the NHS Appointments Commission*. *NHS Employers* will be responsible for administration of the list.
5. Recruitment to the list will be in accordance with published selection criteria drawn up in consultation with stakeholders, including the *BMA*, *BDA*, defence organisations, the *NCAA* and *NHS Employers*. These stakeholders will also assist in drawing up the selection criteria and in seeking nominations to serve.
6. The *Department of Health*, in consultation with *NHS Employers*, *the BDA* and the *BMA* will provide a job description based on the Competence Framework for Chairmen and Members of Tribunals, drawn up by the *Judicial Studies Board*. The framework, which can be adapted to suit particular circumstances sets out six headline competences featuring the core elements of law and procedure, equal treatment, communication, conduct of hearing, evidence and decision making. Selection will be based on the extent to which candidates meet the competences.

7. Panel members will be subject to appraisal against the core competences and feedback on performance provided by participants in the hearing. This feedback will be taken into account when reviewing the position of the panel member on the list.
8. The level of fees payable to panel members will be set by *NHS Employers* and paid locally by the employing organisation responsible for establishing the panel.
9. List members will be expected to take part in and contribute to local training events from time to time. For example, training based on generic tribunal skills along the lines of the Judicial Studies Board competences and /or seminars designed to provide background on the specific context of NHS disciplinary procedures – including the expectations of employers and representatives, could be provided with support from *NHS Employers*, the *National Clinical Assessment Authority* and other stakeholders.

# Maintaining High Professional Standards in the Modern NHS

## *V. Handling concerns about a practitioner's health*

### Contents

#### **Introduction**

*Retaining the services of individuals with health problems*

*Reasonable adjustment*

*Handling Health Issues*

## **Maintaining High Professional Standards in the Modern NHS**

### **V. HANDLING CONCERNS ABOUT A PRACTITIONER'S HEALTH**

#### **INTRODUCTION**

1. A wide variety of health problems can have an impact on an individual's clinical performance. These conditions may arise spontaneously or be as a consequence of work place factors such as stress.
2. The principle for dealing with individuals with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained ( for example if they cannot undertake exposure prone procedures) and kept in employment, rather than be lost from the NHS.

#### **Retaining the services of individuals with health problems**

3. Wherever possible the Trust should attempt to continue to employ the individual provided this does not place patients or colleagues at risk.

#### **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;
- reassign them to a different area of work;
- arrange re-training or adjustments to their working environment , with appropriate advice from the NCAA and/or deanery , under reasonable adjustment provision in the Disability Discrimination Act 1995.

#### **Reasonable adjustment**

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

**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

5. In some cases retirement due to ill health may be necessary. Ill health retirement should be approached in a reasonable and considerate manner, in line with NHS Pensions Agency Advice. However, it is important that the issues relating to conduct or capability that have arisen are resolved, using the agreed procedures where appropriate.

**HANDLING HEALTH ISSUES**

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

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

8. The occupational physician should agree a course of action with the practitioner and send his/her recommendations to the Medical Director and a meeting should be convened with the Director or Head 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)<sup>12</sup>. The practitioner may wish to bring a support companion to these meetings. This could be a family member, a colleague or a trade union or defence association representative. Confidentiality must be maintained by all parties at all times.
9. If a doctor or dentist's ill health makes them a danger to patients and they do not recognise that, or are not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and the professional regulatory body must be informed, irrespective of whether or not they have retired on the grounds of ill health.
10. In those cases where there is impairment of performance solely due to ill health, disciplinary procedures would only be considered in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the employer to resolve the underlying situation e.g. by repeatedly refusing a referral to the Occupational Health Service (OHS) or the NCAA. In these circumstances the procedures in part IV should be followed.
11. There will be circumstances where an employee who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the employer is expected to refer the doctor or dentist to the OHS for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the OHS under these circumstances, may give separate grounds for pursuing disciplinary action.
12. Special Professional Panels (generally referred to as the "three wise men") were set up by District Health Authorities under circular HC(82)13. This responsibility was not transferred to Trusts and the process has fallen into disuse in most parts of the country. This part of the framework replaces HC(82)13 which is cancelled and any existing panels should be disbanded.

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<sup>12</sup> In the absence of a Medical Director organisations should put in place appropriate measures as part of agreed arrangements for small organisations to ensure the appropriate level of input to the process.

# Maintaining High Professional Standards in the Modern NHS

## Guidance on clinical academics

(including an Outline Protocol between University and Trust)

## CLINICAL ACADEMICS

### BACKGROUND

The "*Restriction of Practice and Exclusion from Work Directions 2003*" direct NHS bodies to comply with the framework contained within the document "*Maintaining High Professional Standards in the Modern NHS*". This introduced a new framework for the initial handling and investigation of concerns about the conduct and performance of medical and dental employees. It also introduced a framework for restriction of practice and exclusion from work; it replaces existing guidance on the suspension of doctors and dentists.

In the framework the Department said that NHS bodies 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 honorary contracts. This should be achieved by agreeing a protocol. The draft model protocol mentioned in the framework is attached to this guidance note.

### GUIDANCE

1. The Follett report made a number of recommendations about disciplinary procedures. In particular it said:

“..we are quite clear that here too robust joint working must be the norm. However, we believe that joint working must extend to the prior phase of managing and helping poor performance and seeking remedial measures. It is only when these have run their course without success that formal disciplinary procedures come into play.”
2. In discussions with the Universities and Colleges Employers Association (UCEA), Universities UK (UUK), and the Council of Heads of Medical Schools (CHMS), the Department of Health has agreed that the following four key elements are necessary for the successful handling of concerns about a doctor with both an honorary and substantive contract:
  - Appraisals are jointly undertaken by the University and the Trust.
  - The express permission of the doctor involved is obtained for the exchange of both personal data (for example name, address, registration number, qualifications) and sensitive personal data (for example medical records) between University and Trust.
  - Honorary NHS contracts for clinical academic staff contain a clause that states that the employee must have a substantive contract with the University to hold the honorary NHS post, and that, if the University post is terminated, for whatever reason, the Trust reserves the right to review the continuation of the honorary contract (the “inter-dependency clause”).

- The Trust and University develop strong, co-partnership relations with each other and ensure jointly agreed procedures are in place for dealing with any concerns about doctors with honorary NHS contracts.
3. Similar arrangements should apply to doctors holding honorary academic contracts with a university.
  4. A Revised Model Statute for universities on dismissal, discipline and grievance procedures for academic staff has been approved by the Privy Council, and recommended to universities. It will be for them to decide on implementation. The UCEA has urged them to implement the provisions within the Revised Model Statute relating to clinical academic staff as soon as possible.
  5. The success of the contracts rests with the joint working of the university and NHS Trust. Although each employer (university or NHS Trust) can only make a decision to discipline or dismiss a member of staff under its own procedures. It is therefore recommended that a protocol should be agreed to permit the joint working necessary to ensure contractual inter-dependence, if both employers choose that route. Implementation of the Revised Model Statute will enable universities to adopt the new procedures.
  6. A draft protocol - "Outline Protocol between University and Trust"- is attached as an appendix. This provides for a good practice way of working, with reference to disciplinary matters and dismissal.

## **APPENDIX**

### **OUTLINE PROTOCOL BETWEEN UNIVERSITY AND TRUST**

1. The following general principles and procedure are the result of agreement between the University and such NHS Trust and Provider Units (hereafter called "the Trust") in which University clinical academic staff may hold honorary NHS contracts and is intended to provide a framework for co-operation between University and Trust as employers of the clinical academic staff.

#### **General Principles**

2. The substantive academic contract and the NHS 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 the clinical duties under the honorary NHS contract is essential for the full and proper performance of the duties under the substantive academic contract.
4. The University and the Trust should therefore seek to ensure 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.

#### **Contracts of Employment**

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

#### **Disciplinary and other Procedures**

6. 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
7. 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:- [list the relevant procedures]

8. 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) that 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.
9. 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) [give details];
  - b) the following issues of conduct are matters which would ordinarily fall to be dealt with under the Trust's disciplinary procedure(s) [give details]; and
  - 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**

10. Where 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 party considering the instigation of disciplinary procedures which may result in dismissal shall notify the other of that fact [it would be useful to set out the relevant points of contact eg respective HR Directors] and shall 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 shall consider whether the case is such that both parties would have grounds for instituting disciplinary proceedings and, if that is the case, agree whether action is to be taken under each of their appropriate disciplinary procedures and the sequence in which those procedures shall be operated.
  - d) any party considering restriction of practice or exclusion from work of the clinical academic shall advise the other of its proposal to restrict or suspend and discuss this prior to the clinical academic being so restricted or suspended, where it is practical to do so.
  - e) the University and the Trust shall liaise with each other on the steps to be taken under the applicable disciplinary procedure or procedures, in particular as regards representation by both employers on any disciplinary panel established under any of their applicable procedures and the facilitation of the calling of witnesses and/or 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) shall keep the other informed of the progress and outcome of their respective procedures, including of any appeal.
11. While the University and the Trust shall 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 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**

12. The University and the Trust shall agree procedures for the joint appraisal of members of clinical academic staff and ensure that such 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**

13. 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, each will advise the other of that fact [ again it may be useful to specify the points of contact eg HR director] and shall discuss:
- a) whether action is to 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 its proposal 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 adviser 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 shall discuss the questions/issues to be raised with such medical adviser, in particular any issues arising under the Disability Discrimination Act 1995, including any duty to make reasonable adjustments.
14. The University and the Trust shall keep each other advised of the actions taken under their applicable procedures, including the outcome of any appeal.
15. While the University and the Trust shall 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 that 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**

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

### **Other general provisions regarding co-operation**

17. The University and Trust shall 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 (ie 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 (ie 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 of personal data or sensitive personal data) under the Data Protection Act 1998, whether with or without the consent of the member of staff concerned. 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.

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

**This appendix has been drafted at the request of the Universities and Colleges Employers Association by Pinsents, solicitors, 1 Park Row, Leeds, LS1 5AB. In the event of any queries, please contact Chris Mordue, Partner (0113 244 5000 or [christopher.mordue@pinsents.com](mailto:christopher.mordue@pinsents.com))**