University Hospitals of Leicester NHS
NHS Trust

CONCERNS, CONDUCT, CAPABILITY, ILL HEALTH & APPEALS

POLICY AND PROCEDURE

FOR MEDICAL PRACTITIONERS

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This version replaces the old cat A, Trust Ref: A2/2005. PGC is aware of the Trust Board's decision. Agreed 11th April 2024.

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

September 2015 - This policy was reviewed in line with Maintaining High Professional Standards in the Modern NHS (HSC 2003/12) and references MHPS throughout. Changes in September 2015 include an additional section on handling concerns raised from outcome outlier alerts.

September 2018 – Amendments made:

- Addition of definitions and abbreviations
- Opportunity for a practitioner to provide written factual comment moved from 'Action When a Concern Arises' section to 'Capability Procedure' section
- National Clinical Assessment Service (NCAS) renamed NHS Resolution's Practitioner Performance Advice service
- NHS Resolution's Practitioner Performance Advice service contact details updated
- Procedure added for when concern raised about Agency practitioners
- Additional statement that investigation may take longer than 4 weeks

KEY WORDS

Medical Staff	Ill Health	Disciplinary	Capability
Appeal	Conduct	MHPS	Concerns
Outcomes	Alerts		

1 INTRODUCTION AND OVERVIEW

1.1 The University Hospitals of Leicester NHS Trust is committed to ensuring patient safety through the maintenance of excellence in clinical care. A fundamental part of this commitment relates to how concerns regarding medical practice are handled. The intention underlying the process outlined below is to:

- Protect patients
- Support the continuing professional development of clinicians
- Promote excellence in medical practice
- Create a learning culture where clinicians receive personal development to encourage review of their practice, work in an open and accountable manner and develop continuously.
- To maintain the Trust's duty of care to ourstaff.

1.2 In order to comply with Maintaining High Professional Standards in the Modern NHS (HSC 2003/12), the Trust has put in place this policy and procedure which applies to all grades of medical and dental staff (referred to as the "practitioners") employed by the Trust.

1.3 This policy and procedure provides guidance on the following and must be read in conjunction with the relevant section of Maintaining High Professional Standards in the Modern NHS (known as MHPS):-

- Dealing with initial concerns
- Exclusions/restrictions on practice
- Conduct
- Capability
- Health

2 POLICY SCOPE

2.1 This policy and procedure applies to all Medical and Dental Staff (practitioners) employed by the Trust (to include substantive, locum, those on honorary contracts and clinical placements).

2.2 This policy also provides guidance when concerns arise with a practitioner working at the Trust through and agency.

2.3 For doctors in training, the Trust and Deanery would seek to ensure joint co-operation and agreement in the management and support of issues relating to the conduct, capability or health of a practitioner.

2.4 Case Managers and Investigators must complete training as per section 6 prior to undertaking the role.

3 DEFINITIONS AND ABBREVIATIONS

Alerts - A system used by some specialist societies or monitoring bodies to identify and notify outliers in clinical outcomes.

Capability - The Employment Rights Act 1996 identifies capability or qualifications as one of the six potentially fair reasons for dismissal. It states that "capability is assessed by reference to skill, aptitude, health or any other physical or mental quality". It also indicates the "incapability must relate to the work or kind of work that the employee was employed by the employer (Trust) todo".

GDC - General Dental Council

GMC - General Medical Council

MDT – Multi Disciplinary Team

MHPS – Maintaining High Professional Standards in the Modern NHS

Outlier - A term used to indicate that when an individual's outcome data is analysed, their results are statistically different than their peers (and for these purposes worse).

4 ROLES

4.1 **All medical and dental staff** have a responsibility to raise genuine concerns with their Head of Service / Medical Lead. There will usually be a requirement to document concerns and where appropriate concerns can be raised through the Public Interest Disclosure Act 1998 (Whistleblowing in the NHS).

4.2 **Heads of Service / Medical Leads / Senior Managers** have a responsibility for escalating serious issues to the Clinical Director, who will where necessary raise concerns to the Medical Director.

4.3 **Board Director Lead -** The **Director of People and Organisational Development (OD)** has joint responsibility with the **Medical Director** for managing exclusion procedures and for ensuring cases are properly managed. In cases where immediate exclusion is required the above parties must discuss the case at the earliest opportunity following exclusion, preferably at a case conference.

4.4 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. In cases of exclusion, the Case Investigator will provide factual information to assist the Case Manager in reviewing the need for exclusion and making reports on progress to the Director of People and OD and the Medical Director (where he/she is not the Case Manager) or designated Board member.

4.5 A Non Executive Director known as the **Designated Member** is appointed at the point of exclusion or from when the initial investigation of the case is likely to lead to dismissal e.g. gross misconduct or a serious breach of the medical code of practice. For other cases, if during the investigation it becomes apparent that a dismissal sanction may be a recommendation from the Case Manager then a NED would immediately be involved at that stage.

4.6 The **Case Manager** oversees the investigation and ensures the investigation proceeds in a timely fashion. The Case Manager determines the terms of reference for the investigation, referring to the relevant policies and also makes the decision as to the appropriate course of action following the completion oftheinvestigation.

4.7 The **Case Investigator** undertakes the investigation into the concerns with a representative from Human Resources and presents the findings to the Case Manager.

4.8 At any stage of the handling of the case, the Case Manager should give consideration to the involvement of the NHS Resolution's Practitioner Performance Advice Service**.**

4.9 An **Independent Practitioner** (from another NHS organisation) must be called upon to advise on cases concerning complex clinical issues. In addition, in cases of potential misconduct, where the investigation identifies issues of professional conduct, the Case Investigator must obtain independent professional advice. If such a case proceeds to a hearing under the Disciplinary Policy (A6/2004), an independent practitioner from another NHS organisation must sit on the panel.

4.10 The **Responsible Officer (RO)** has statutory duties under the Medical Profession (Responsible Officers) Regulations 2010 regarding the addressing and investigation of concerns. Where the role of RO is separated from the role of Medical Director, the two will work closely together to ensure that the statutory obligations are met.

4.11 The **Director of Medical Education** should be informed of any concerns relating to practitioners in training grades. The Director of Medical Education will inform the Postgraduate Dean, who is the 'Responsible Officer' for trainees, of any concerns through an exception report, for the purpose of revalidation.

4.12 The **Generalist HR Department** provide advisory support throughout all formal investigations under this policy.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 Concerns may be raised regarding a practitioner's capability or conduct in a routine manner, which is a normal part of the operation of the service. Any concerns (serious or not) should be dealt with as they arise.

5.2 The following procedure is designed for such instances where serious concerns are lodged regarding a practitioner's conduct or capability.

5.3 A serious concern about capability or conduct will arise when the practitioner's actions have or may adversely affect patient care. Ultimate responsibility for defining this in individual cases lies with the Medical Director (or delegated person), in consultation with senior HR staff.

5.4 Concerns about the capability or conduct of practitioners in training grades should be considered initially as training issues with the Educational Supervisor and through the Director of Medical Education; the Postgraduate Dean should be involved from the outset.

5.5 Action When A Concern Arises (Part I of MHPS)

5.5.1 Handling Concerns

5.5.1.1 The Medical Director is responsible for the overall management of serious concerns regarding practitioners. If she or he considers that the concern is serious, then the steps outlined below will be taken.

5.5.1.2 A Case Manager is appointed. The Medical Director may act as the Case Manager in cases involving Consultants but may delegate this role to a Deputy/Asst Medical Director or Clinical Director as appropriate taking into account the profile and details of a particular case. Where the Case Manager decides, in consultation with the Medical Director, Director of People and OD and the NHS Resolution's Practitoner Performance Advice Service there is a need for formal investigation, a Case Investigator is appointed by the Medical Director or nominated deputy.

5.5.1.3 When a Case Investigator and a designated HR lead to support the investigation is appointed, the terms of reference for the investigation must be determined by the Case Manager. This is usually in conjunction with the designated HRlead.

5.5.1.4 The Case Investigator, with support from the HR lead will:

- Formally involve a senior member of medical or dental staff where a question of clinical judgement is raised if the Case Investigator is not appropriately qualified/experienced to undertake this role.
- Ensure that there are sufficient written statements to establish a case and ensure that oral evidence is given sufficient weight.
- Produce a written report following the investigation, detailing the conclusions reached.
- Assist the designated board member to review the progress of thecase.

5.5.1.5 It is a requirement of this procedure that a practitioner will be informed in writing by the Case Manager, as soon as it is decided that an investigation is to be undertaken. This must include:

- the name of the Case Investigator
- the specific allegations or concerns that have been raised and any correspondence relating to the case
- the opportunity to see any correspondence relating to the case at the outset of the investigation
- a list of people that the Case Investigator will interview
- an opportunity to put their view of events to the Case Investigator and the opportunity to be accompanied

5.5.1.6 If during the course of an 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.

5.5.1.7 At any point in the process where the Case Manager has reached the clear judgment that a practitioner is considered to be a serious potential danger to patients or staff, that practitioner must be referred to the GMC/GDC, whether or not the case has been referred to the NHS Resolution's Practitioner Performance Advice Service. In these circumstances, the Medical Director and the Designated Member must be informed and consulted with where necessary.

5.5.1.8 MHPS states the Case Investigator should usually complete the investigation within 4 weeks of appointment. Whilst every effort should be made to meet this timeframe there may be circumstances whereby this can not beachieved,

for example availability of witnesses, union representation, obtaining necessary evidence. Where there is an extension to the investigation the practitioner should be notified in writing.

5.5.1.9 The Case Investigator must submit their report to the Case Manager within five days of completion of the investigation. The report should give sufficient information for the Case Manager to make a decision whether:

- There is a case of misconduct that should be put to a conduct panel and to follow the Trust's Disciplinary Procedure (A6/2004)
- There are concerns about the practitioner's health that should be handled through Occupational Health
- There are concerns about performance, which should be referred to the NHS Resolution's Practitioner Performance Advice Service
- Restrictions on practice or exclusion from work be considered
- There are serious matters which should be referred to the GMC or GDC
- There are intractable problems which should be referred to a capability panel
- No further action is required

5.5.1.10 In the event that new issues arise during the course of the investigation, the Case Investigator will:

- Inform the Case Manager in writing of the nature of the new issues that have arisen and supply the supporting evidence.
- The Case Manager, in conjunction with the designated HR lead will decide whether to amend the terms of reference to cover the new issues of concern.
- In the event that the terms of reference are to be varied, the Practitioner will be provided with the amended terms of reference, together with an explanation of why the terms were varied.

5.5.2 Involving NHS Resolution's Practitioner Performance Advice Service

5.5.2.1 At any stage of the handling of a case consideration should be given to the involvement of NHS Resolution's Practitioner Performance Advice Service. The Case Manager, once the nature of the concern is identified, must assess the seriousness of the issue, seeking advice from NHS Resolution's Practitioner Performance Advice Service where necessary. A decision will then be taken whether a formal investigation is required.

5.5.2.2 NHS Resolution's Practitioner Performance Advice Service can be contacted via:

NHS Resolution
2nd Floor 151 Buckingham Palace Road,
London.
SW1W 9SZ Tel. 020 7811 2700

Website: www.NHS Resolution's Practitioner Performance Advice service.nhs.uk
Email: advice@resolution.nhs.uk

5.5.3 Confidentiality

5.5.3.1 The Trust will maintain confidentiality and the information provided externally(for

example to the media) will be restricted only to confirming that an investigation or disciplinary hearing is under way or responding factually to the detail that the media hold.

5.5.4 Support and Right to be accompanied

5.5.4.1 Trust based support should be offered to the practitioner, for example through Occupational Health and AMICA (free and confidential staff psychological and support service), as well as informing them of their right to seek support and representation through their trade union or defence organisation.

5.5.4.2 Any practitioner covered by this policy and procedure may be accompanied by a friend, partner/spouse, work colleague or trade union/defence organisation representative. The companion/representative may be legally qualified but they will not be acting in a legal capacity. This means it is impermissible for a lawyer, either a solicitor or a barrister, to advise as a “friend” on any kind of remunerated basis.

5.5.4.3 Trainee doctors should also be advised of the support available through the Trainee Support Service accessed through Health Education East Midlands (HEEM).

5.5.5 Agency Locums

5.5.5.1 Where a concern is raised regarding an agency locum, the Head of Service, must make the Responsible Officer aware at the earliest opportunity.

5.5.5.2 The Head of Service, or delegated deputy, should investigate the concerns and advise the agency of the investigation.

5.5.5.3 Consideration should be given as to whether the use of the agency practitioner ceases during the investigation.

5.5.5.4 The Head of Service will feed back the investigation finding to UHLs Responsible Officer, who will provide the details to the agency locum’s Responsible Officer.

5.6. Restriction on Practice & Exclusion from Work (Part II of MHPS)

5.6.1 Managing the Risk to Patients

5.6.1.1 When serious concerns are raised about a practitioner, the Medical Director will urgently consider whether it is necessary to place temporary restrictions on their practice.

5.6.1.2 If there is evidence that concerns are related to the practitioner’s health, the Occupational Health Department should become involved at an early stage (see Part V of MHPS).

5.6.1.3 Exclusion of practitioners from the workplace is a temporary expedient. It is a precautionary measure and not a disciplinary sanction, it is reserved for specific circumstances. Alternatives to exclusion must always be considered in the first instance. Exclusion is only potentially justified where:

- There has been a critical incident where serious allegations have been made; or
- There has been a breakdown in relationships between a colleague and the rest of the team; or
- The presence of the practitioner is likely to hinder the formalinvestigation.

5.6.1.4 Before reaching the decision to exclude, it is important to seek NHS Resolution's Practitioner Performance Advice Service's assistance.

5.6.2 The Exclusion Process

5.6.2.1 Where exclusion is required, the process outlined in Part II of MHPS must be adhered to. Part II gives guidance on the following:

- Immediate Exclusion	- Reviewing Exclusions
- Formal Exclusion	- Returning to Work following exclusion

5.7 Conduct Procedure (Part III of MHPS)

5.7.1 All issues regarding the misconduct of medical practitioners will be dealt with under the Trust's Disciplinary Policy and Procedure (A6/2004).

5.7.2 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 independent professional advice.

5.7.3 Concerns about the conduct of practitioners in training grades should be considered initially as a training issue and the Educational Supervisor and through the Director of Medical Education; the Postgraduate Dean should be informed from theoutset.

5.7.4 Allegations of criminal acts should follow the guidance set out in MHPS PartIII.

5.8 Capability Procedure (Part IV of MHPS)

5.8.1. The general principles are as set out in Part IV, paragraphs 1-12 of MHPS.

5.8.2 If the concerns relate to the capability of an individual practitioner, these should be dealt with under this procedure whether arising from a one-off or series ofincidents.

5.8.3 Wherever possible issues of capability shall be resolved through ongoing assessment, retraining and support. If the concerns cannot be resolved routinely by management, NHS Resolution's Practitioner Performance Advice Service must be contacted for support and guidance **before** the matter can be referred to a capability panel.

5.8.4 Any concerns relating to practitioners in training grades must be discussed with the relevant Educational Supervisor and the Director of Medical Education, plus with the Postgraduate Dean, from the outset.

5.8.5 The following are examples of matters which the Trust may regard as being concerns about capability (this is a non-exhaustive list):

- Out of date or incompetent clinical practice
- Inappropriate clinical practice arising from a lack of knowledge or skills that

puts patients at risk;
- Inability to communicate effectively;
- Inappropriate delegation of clinical responsibility;
- Inadequate supervision of delegated clinical tasks; and
- Ineffective clinical team working skills.

5.8.6 In the event that the capability issue has arisen due to the practitioner's ill health, then the Ill Health Procedure in Part V must be considered.

5.8.7 In the event of an overlap between issues of conduct and capability, then usually both matters will be heard under the capability procedure. In exceptional circumstances, it may be necessary for issues to be considered under separate procedures. The decision as to which procedure shall be initiated shall be taken by the Case Manager in consultation with the Director of People and OD and NHS Resolution's Practitioner Performance Advice Service.

5.8.9 The Pre-Hearing Process

5.8.9.1 When a serious concern warrants investigation this will be undertaken in line with section 5.5 'Action When A Concern Arises (Part I of MHPS)'.

5.8.9.2 The Case Manager should give the practitioner the opportunity to comment in writing on the factual content of the Case Investigators report, including appendices however investigatory meeting notes will only be provided to the practitioner should the case proceed to a hearing.

5.8.9.3 The practitioner has 10 working days of receipt of the report to provide comments in writing to the Case Manager. In exceptional circumstances i.e. complex cases or annual leave, the deadline may be extended.

5.8.10 Consideration of the Investigation Report

5.8.10.1 Following submission of the report, the Case Manager shall 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 NHS Resolution's Practitioner Performance Advice Service. The Case Manager will need to consider urgently:

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

5.8.10.2 The Case Manager will need to consider, taking advice where necessary, whether the issues of capability can be resolved through local action (such as retraining, counselling and/or performance review). If this is not practicable for any reason the matter must be referred to NHS Resolution's Practitioner Performance Advice Service for advice as to whether an assessment should be carried out and to provide assistance in drawing up an action plan. A further option is a referral to a capability panel for a hearing.

5.8.10.3 The Case Manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments.

5.8.11 Capability Hearings

5.8.11.1 Time limits for invitation to a hearing and exchange of documents are all set out in Part IV, section 17 of MHPS.

5.8.12 Panel Members

5.8.12.1 The panel for the capability hearing shall consist of at least three people including:-

- An Executive Director of the Trust (acting as Chair)
- A medical or dental practitioner not employed by the Trust (following discussions with the LNC)
- A Board Member or Senior Manager of the Trust.

5.8.12.2 If the practitioner is a clinical academic, a further panel member may be appointed in accordance with any agreed protocol between the Trust and the relevant University.

5.8.12.3 The panel must also be advised by a senior HR professional.

5.8.12.4 The Case Manager should notify the practitioner of the panel members in writing

when notifying the practitioner of the hearing. Within **5 working days** of their being notification, the practitioner should raise with the Case Manager any objections to the panel members. If termination of employment is a potential outcome of the hearing this should also be included when notifying the practitioner of the hearing.

5.8.13 The Capability Hearing

Part IV, Section 23 of MHPS outlines how Capability Hearings are to be conducted.

5.8.14 The Decision

5.8.14.1 The panel has the discretion to make a range of decisions. A non-exhaustive list of possible decisions include:

- No action required;
- Verbal agreement by the practitioner that there will be an improvement in clinical performance within a specified timescale confirmed in a written statement as to what is required and how it is to be achieved;
- A written warning to improve clinical performance within a specified timescale with a statement which is required and how this can be achieved;
- A final written warning that there must be improved clinical performance within a specified timescale and how this can be achieved;
- Demotion / Transfer
- Termination of employment.

5.8.14.2 The decision must be confirmed in writing to the practitioner within 10 working days of the hearing and communicated to the Case Manager within the same timescale. The letter to the practitioner must include reasons for the decision, confirmation of the right of appeal and notification of any intention to make a referral to the GMC/GDC or any other external professional body.

5.8.14.3 Any decision must be placed in the practitioner's personal file. A verbal agreement should remain live on the file for six months, first written warnings for twelve months and final written warnings for twenty four months.

5.8.14.4 Appeals against a decision must be received in writing within 25 working days of the capability hearing, submitted to the Director of People and OD. Appeals must set out specific grounds upon which the practitioner wishes to base their appeal otherwise the appeal may not beallowed.

5.8.15 Capability Appeals Procedure

Part IV, sections 28 to 46 of MHPS outline the role and structure of an appeal panel, the procedure and the mechanism of communicating the decision.

5.8.16 Other Issues

5.8.16.1 If a practitioner leaves the Trust's employment prior to the conclusion of the above processes, the capability proceedings must be completed wherever possible. This applies whatever the personal circumstances of the practitioner.

5.8.16.2 Where during the capability process a practitioner becomes ill, appropriate action should be taken under the Sickness Absence Management Policy and Procedure (B29/2006) and Part V of MHPS.

5.8.16.3 Where a practitioner's employment is terminated on ill-health grounds the Trust shall still take the capability procedure to a conclusion.

5.9 Concerns About A Practitioner's Health (Part V of MHPS)

5.9.1 This part applies to the following circumstances:

- where the practitioner is off sick and no concerns have arisen about conduct or capability;
- where the issues of capability or conduct are decided by the Case Manager to have arisen solely as a result of ill-health on the part of thepractitioner;
- where issues of ill-health arise during the application of the procedures for addressing capability or conduct.

5.9.2 This section should be read in conjunction with the Trust's Sickness Absence Management Policy and Procedure (B29/2006).

5.9.3 Where a practitioner has been off sick for a continuous period of four weeks and there is no anticipated date for the practitioner's return to work and no concerns about capability or conduct have arisen, the Trust's Sickness Absence Management Policy and Procedure (B29/2006) will be followed by the line manager with support from HR. In addition advice from NHS Resolution's Practitioner Performance Advice Service can be sought following Occupational Health advice.

5.9.4 In the event that the Case Manager considers that the capability or conduct concerns may have arisen because of a practitioner's ill-health, he/she should refer the practitioner to Occupational Health.

5.9.5 Once the Case Manager has the report from Occupational Health, he/she should decide whether he/she is satisfied that any concerns have arisen from ill-health rather than misconduct or incapability.

5.9.6 If a practitioner argues that the concerns are caused by ill health, Occupational Health advice must be sought. NHS Resolution's Practitioner Performance Advice Service advice can also be sought to aid the Case Manager in their decision to deal with the concerns as an ill-health issue or under the capability or conduct procedure as appropriate.

5.9.7 Reporting Practitioners with health concerns to Regulatory Bodies
If a practitioner's ill-health makes them a danger to patients and he/she does not recognise this or is not prepared to co-operate with measures to protect patients, then exclusion from work must be considered and is potentially justifiable. Furthermore, NHS Resolution's Practitioner Performance Advice service, GDC or GMC must be informed irrespective of whether or not the practitioner has retired on ill health grounds.

5.10 Concerns Arising From Outcome Outlier Alerts (Part VI of MHPS)

5.10.1 This part applies to the circumstances of a practitioner's outcomes triggering an alert because outcomes are not within expected measures.

5.10.2 There are a large number of sources of outcome data, and many of these can be associated with individual clinicians. Examples include specialist society data, such as that published by the Society of Cardiothoracic Surgeons (SCTS) for individual surgeons; Dr Foster, and CRAB (Copeland's Risk Adjusted Barometer). In addition internal audits may also flag data to individualclinicians.

5.10.3 When performance is monitored in this way, it will inevitably start to identify some mortality or complication rates that are higher than expected. This may be due to chance, to quirks of case mix, to issues with data accuracy and validity or to sub-optimal performance in some part of the process (remembering that the clinician is not the only variable in the management of the patients).

5.10.4 UHL subscribes to the methodology recommended by the SCTS for dealing with such outliers, which they call "explaining divergence". The recommended approach is based on the following principles:

- The process must be reasonable andproportionate;
- This process should not lead to patients who are high risk being denied surgery or other appropriate interventions.
- Divergence from expected outcomes should be classified according to its level and frequency
- Divergence is a cause for looking at the data in more detail and is not, on its own, a reason for restricting a clinician's practice;
- The mechanisms for supporting a hospital or clinician, and explaining abnormal mortality rates must be separate

5.10.5 Explanation should proceed in four stages:
- Analysis of the data for accuracy
- Analysis of the caseload to ensure that the risk stratification mechanism accurately reflects expected outcomes
- Analysis of institutional factors that may contribute to the divergence in clinical outcomes
- Analysis of the clinician's performance

5.10.6 When a concern arises about a clinician's outcomes, the Clinical Director must be informed. If the alert is raised with the clinician directly (for example a "yellow" alert from a specialist society), they must inform their clinical director as soon as is practically possible.

5.10.7 The clinician will meet their clinical director as soon as possible upon receipt of an alert to discuss whether any immediate steps are necessary for the protection of patients and/or for the well-being of the clinician. Considerations will be in line with the guidance above, and might (but will not necessarily)include:

- transfer of high risk patients on the clinician's waiting list to colleagues until the matter is investigated further;
- new high risk patients to be transferred to colleagues from the point of referral until the matter is investigated further
- support for the clinician from colleagues if high risk cases are undertaken when on-call
- examination of cases of non-survival and complications to identify commonthemes
- appropriate offer of support to the clinician as required, including consideration of pastoral care, formal support from colleague(s), mentoring, occupational health, or any other support thought to be helpful.

5.10.8 This meeting will be documented, and an outcome letter kept on file by the clinical director. The Medical Director will be informed of the meeting and any actions agreed at this stage. The Clinical Director and Medical Director might consider seeking advice on the matter, for example from a specialist society, NHS Resolution's Practitioner Performance Advice Service, or an invited review mechanism from a Royal College.

5.10.9 If the conclusion of that meeting is that the performance of the clinician is in doubt then specific recommendations should be considered as necessary to improve performance. Such measures should be agreed with the clinician wherever possible. Examples might include:

- Identifying support available for procedures,
- A period of supervised practice,
- Restriction of caseload to procedures for which outcomes are notoutlying;
- Discussion of cases with a named colleague;
- Consideration of supervision of trainees;
- Avoiding high risk cases;
- Use of wider MDT discussion for case selection / analysis;
- Occupational health review

5.10.10 Any recommendations, including a decision to place restrictions on clinical practice, must be put in writing to the affected clinician and their clinical line manager. Furthermore, if support/monitoring of any type is required, the restrictions and nature of support/monitoring required by peers must be agreed and put in writing to those peers in line with the UHL Remediation Policy for Medical and Dental Staff (B15/2015).

5.10.11 If retraining is considered a desirable outcome then this should be done in linewith the UHL Remediation Policy for Medical and Dental Staff (B15/2015).

5.10.12 In cases where performance concerns are serious or have not been addressed through the above recommendations, Part 1 of this policy should apply or where remediation has occurred, NHS Resolution's Practitioner Performance Advice Service may advise to progress to a capability hearing.

6. EDUCATION AND TRAINING REQUIREMENTS

6.1 A Case Manager must have completed the NHS Resolution's Practitioner Performance Advice Service Case Manager training.

6.2 A Case Investigator must have completed the NHS Resolution's Practitioner Performance Advice service Case Investigator training.

7. PROCESS FOR MONITORING COMPLIANCE

7.1 Compliance with the policy is ensured through the HR support and advise provided throughout action taken under this policy.

7.2 All medical conduct and capability cases are monitored on a monthly basis via the Medical Conduct Meeting which is attended by the Medical Director and the Director of People and OD.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Compliance Against Policy Timescales	**HR Lead**	**Medical Conduct Meeting with Medical Director and Director of HR**	**Monthly**	**Database maintained by HR to track all live cases and archive closed cases.**
Managing Exclusions	**Case Manager in conjunction with HR.**	**Exclusions to be managed in line with Part 2 and MHPS.**	**As per exclusion timelines in MHPS.**	**Medical Conduct Group.**
Production of a written report (as per Part I) following the conclusion of the investigation detailing recommendations.	**Case Investigator**	**With support from Human Resources**	**To be submitted to the Case Manager within 5 working days of completion of the investigation.**	**Case Manager to review and take further action as necessary.**
Notification of investigation and terms of reference to be sent to practitioner as soon as decision is taken to proceed.	**Case Manager**	**With support from Human Resources**	**As soon as decision is taken to proceed with a formal investigation.**	**Case Investigator to commence investigation.**
Investigation completed within 4 weeks, or extension confirmed.	**Case Investigator.**	**With support from Human Resources**	**4 week review.**	**Case Investigator and HR to review progress.**
Arrangement of formal hearings	**Case Manager and Human Resources**	**With support from Human Resources**	**Timescales to be followed in line with this policy or Disciplinary Policy and Procedure (A6/2004).**	**Case Manager, Investigator and HR.**
Confirmation of hearing decisions.	**Chair of Hearing Panel**	**With support from Human Resources**	**Within 10 working days of the hearing.**	**Chair of Panel with HR support.**
Appeals	**Chair of Panel and Human Resources**	**Human Resources**	**Appeals to be received within 25 working days of appeal hearing.**	**Human Resources**

NB: Paper copies of this document may not be most recent version. The definitive version is held on INsite Documents

8. EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Maintaining High Professional Standards in the Modern NHS (2003/12)

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072773

Public Interest Disclosure Act (1998)

http://www.legislation.gov.uk/ukpga/1998/23/contents

Society of Cardiothoracic Surgeons "Maintaining Patient's Trust – Modern Medical Professionalism. Pages 36 to 43. "Explaining Divergence"

http://www.scts.org/_userfiles/resources/634420268996790965_SCTS_Professionalism_FINAL.pdf

UHL Policies and Procedures:

- Disciplinary Policy and Procedure A6/2004
- Sickness Absence Management Policy and Procedure B29/2006
- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy A15/2001
- UHL Remediation Policy for Medical and Dental Staff B15/2015
- Anti-Bullying and Harassment Policy and Procedure B5/2016

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be uploaded onto INsite Documents and available for access by Staff. It will be stored and archived through the SharePoint system.

This policy will be reviewed in September 2021 or sooner should significant changes be required.