Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Medical Remediation and Disciplinary Policy

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1 Introduction

This is an agreement between Tees, Esk and Wear Valleys NHS Foundation Trust (the Trust") and the Local Negotiating Committee (LNC) outlining the Trust's procedure for handling concerns about doctors' conduct and capability.

Whilst regard has been had to the framework set out in "Maintaining High Professional Standards in the Modern NHS", ("MHPS") issued under the direction of the Secretary of State for Health on 11 February 2005, both parties have agreed that this procedure and not MHPS shall apply to potential disciplinary or capability concerns.

Whilst both the Trust and doctors subject to this policy are expected to follow the provisions set out in this policy nothing in the document shall be contractually binding.

This procedure has been developed to support the management of concerns about the performance/behaviour of doctors across the Trust. With early intervention and prevention, possible restriction or exclusion from practice can be avoided.

With doctors in training, concerns about their capability, dependent on the circumstances, should be considered initially as training issues and the postgraduate dean should be involved from the outset. Concerns about the conduct or capability of doctors on placement with the Trust, will be referred to the relevant employing authority.

2 Why we need this policy

2.1 Purpose

The purpose of this document is to provide the reader with a structured flow through remediation and low level concerns into more serious concerns. This policy has been separated into part one and part two to distinguish between low level and high level concerns.

3 Scope

3.1 Who this policy applies to

This policy applies to all medical staff employed by the Trust.

3.2 Roles and responsibilities

Role	Responsibility
• Chair • Chief Executive • Medical Director • Designated Board Member • Associate Director of Medical Development • Clinical Managers • Case Managers • Case Investigators • Doctors • Doctor's Companions	To ensure that actions taken under this policy and procedure are fair and consistent.

4 Policy – Part 1

4.1 Action to take when a concern arises

The management of performance and/or behaviour is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a doctor's performance and/or behaviour 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 resort to disciplinary sanctions.

Concerns can be raised by anyone at any time and come to light in a variety of ways. This may be through appraisal, audits, mentoring, peer groups, peer supervision by a Clinical Manager or reports from dashboards, colleagues, patients, disciplinary procedures, and fitness to practice panels or other sources.

4.1.1 What to do when a concern comes to light

Upon receipt of an allegation, complaint or concern, it must be considered and a decision made as to the nature and seriousness of it. A concern will normally be communicated to the Clinical Manager of the doctor in the first instance and an initial judgment made which may involve a short fact find. Advice should be taken from Medical Development.

Minor concerns will normally be addressed through normal continuing professional development processes and if the Clinical Manager believes that no further action should be taken, they will make a file note for the individual's personal file and send a copy to Medical Development for recording on a central system. If the concern/issue is considered more serious, it will be referred to the DMG (please see page 14). In some cases the concerns may immediately go straight to DMG.

The DMG will then consider whether the behaviour of the doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or impacts adversely on the reputation of the Trust or where the doctor develops a pattern of repeating mistakes, or appears to behave in a manner inconsistent with the standards described in *Good Medical Practice.* The concern/issue will immediately be considered by the DMG which will decide whether the issue or issues should be dealt with as a low level or a serious concern. At any stage the DMG may review this decision if further information comes to light.

4.1.2 Dealing with serious concerns

If the DMG results in a decision that the concern is serious, the DMG will hold a case conference and this will involve the Medical Director or suitable deputy, the Clinical Manager and a Medical Development representative. Whilst it is likely that this will lead to a formal investigation, it may also be re-classified as a low level concern or alternatively require further facts to be gathered before a decision can be made. (Refer to section 5)

4.1.3 Dealing with low-level concerns

Remediation is the process that will address low level behaviour/performance concerns (knowledge, skills and behaviours) which provides help; such as management advice, behavioural plans, formal mentoring, further training, re-skilling or rehabilitation.

Clear goals with timescales will be written into a plan and shared with the doctor. If the Clinical Manager is then satisfied with the outcomes, a 'file note' will be written for the doctor's personal file and a copy sent to Medical Development for recording on the central system as outlined above. (Refer to section 3)

If the doctor has not met the objectives at the end of the timescale a case discussion will be held and a decision taken as to whether to refer to the DMG to consider whether to formally investigate the concerns identified. If the DMG decides to proceed to formal investigation then the Clinical Manager will become the 'Case Manager'. The DMG will then appoint a 'Case Investigator' and should the concerns be of a clinical nature, a 'Clinical Advisor' will be identified to support the Case Investigator. Should the Clinical Manager be unable to assume the role of Case Manager because they are likely to be involved in the investigation, a different Case Manager will be appointed.

4.1.4 Health-related factors

It should be noted that when a concern arises, consideration must be given by the Clinical Manager as to whether the concern is related to a health issue. The principle for dealing with individuals with health problems is that, wherever possible, they should be treated, rehabilitated or re-trained and kept in employment. When such a health concern arises, the Clinical Manager will consult with Medical Development and a decision made as to whether the Trust Health at Work Policy will be followed from this point. (Please see section 9) for further information.

The flow chart overleaf provides a simple illustration of this process and the key stages where decisions are required about how to proceed.

4.1.5 Support for doctors

Being involved at any stage of the medical remediation and disciplinary procedure can be a stressful time and as such the Trust wants to ensure it provides as much support as possible during this period.

The Trust has a number of consultant colleagues that are able to provide support and guidance (see appendix 8) for further information.

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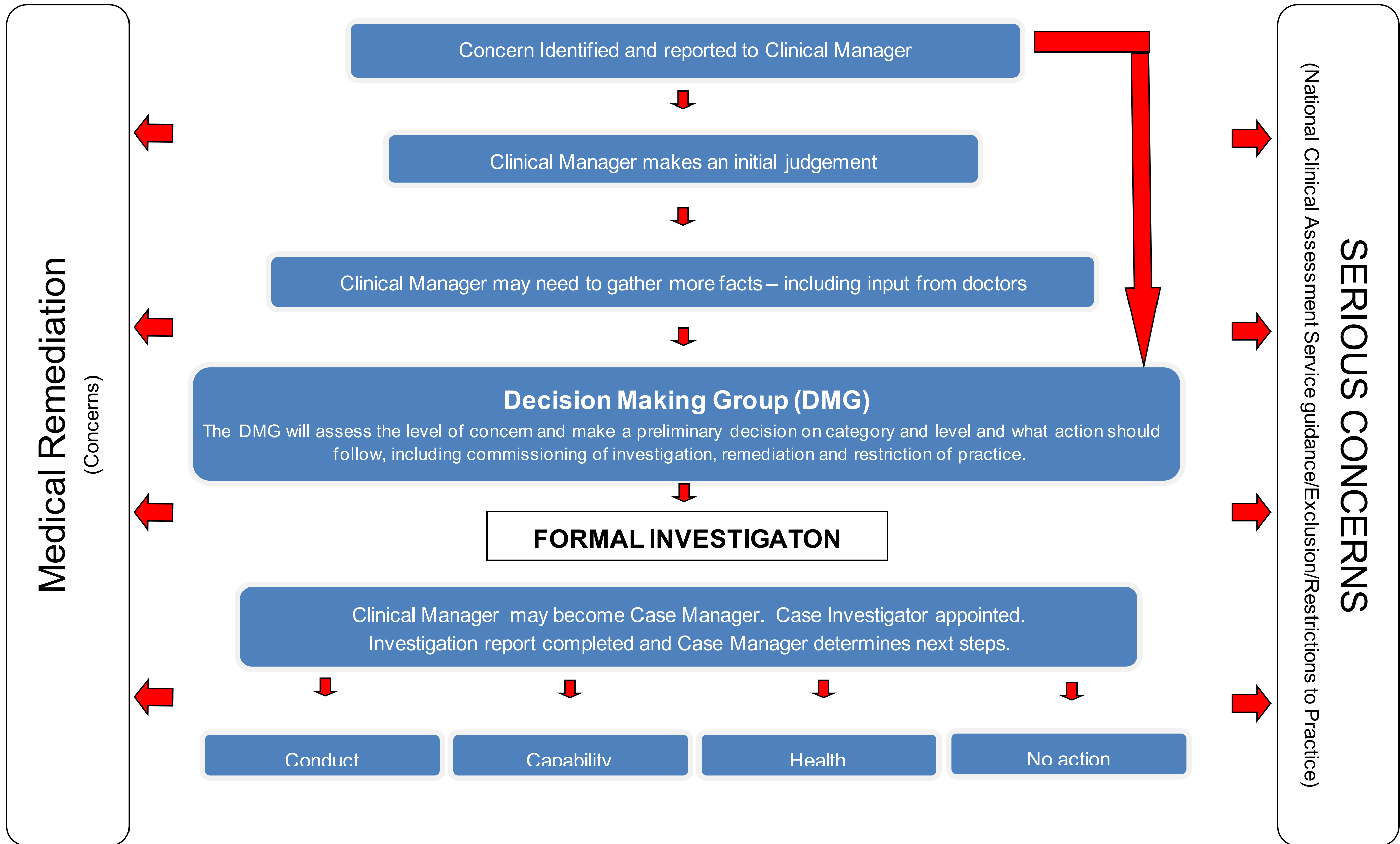
Process Flowchart - Action to take when a concern arises



4.2 Low level concerns - remediation

The Clinical Manager will meet with the doctor and discuss the concerns that have been raised. The Clinical Manager will outline how they expect that the doctor will improve and establish an action plan to help support that goal. Clear targets with timescales will be written into the plan and shared with the doctor, where it is felt that this is necessary.

The action plan will be a developmental/educational contract between the doctor and the Trust. It will describe how the doctors identified needs (clinical, behavioural and/or health) should be addressed and the outcomes must be practical, feasible and affordable. The action plan will be clear and detailed in terms of:

- Personal objectives
- Support arrangements
- Process for monitoring and review/re-assessment
- Expected outcomes

When creating an individual remediation action plan, there are a number of different options for intervention. These can cover supervision, development and the scope of the doctor's work. Interventions that could be considered include:

Intervention	Example
Supervised practice	
Work-based assessments	Case based reviews Mini Cex OSCEs OSATS Video recording Simulation Multi source feedback
Educational activities	Tutorials Workshops Course E-learning Focused reading Language/communication skills based activities
Specialist interventions	Behavioural coaching Health interventions Counselling (career & therapeutic)
Practice support	Mentoring Vocational rehabilitation Protected learning and development time

Further guidance on the types of remediation can be found in appendix 2.

A further meeting will take place at the end of the period identified to meet the objectives. Should progress not have been made as expected and/or the doctor is unable or unwilling to address the concerns, the following options will need to be considered:

- Further period of time to meet actions
- Matter referred to DMG for consideration of capability/conduct procedures
- Change in job plan (restricted duties)
- Retirement
- Regulatory involvement
- Health professional alert notices

The process for responding to concerns and managing remediation is confidential, with details shared on a need to know basis. Details discussed/released to others must be appropriate for the purpose and not disproportionate to the seriousness of the concern.

A simple record will be kept within the Trust, recording all concerns within the scope of this policy. Access to information will be restricted to the Medical Director, Deputy Medical Director Medical Development, appropriate Clinical Managers and members of the revalidation group.

As a minimum the details to be recorded will include:

- Date concern raised
- Type of level of concern
- Brief summary of action & current progress
- Date of next review
- Remediation action plans and other records will be kept in the doctor’s personnel file

Records that are kept may be used in the future should similar low level concerns establish themselves as patterns. In this instance, the Clinical Manager will review all data available and decide whether the matter is re-classified and passed to the DMG.

In respect of clinical academics, discussions will take place with the relevant University.

5 Policy Part 2 – Serious Concerns

5.1 Establishing that a concern is serious

A serious concern will normally arise when the Clinical Manager has gathered preliminary facts. This will normally involve an initial assessment of the nature of the concerns and its seriousness. In some cases the concerns may immediately go straight to DMG. The DMG will be chaired by the Medical Director (or Deputy) and a representative from Medical Development, and include the Clinical Manager. The DMG may have regard to information supplied by the police or NHS Counter Fraud. Restrictions to practice, Exclusion and NCAS involvement will be considered and a Case Manager and Case Investigator appointed.

The DMG will take into account in its decision making process whether the Clinical Manager is a non-medical member of staff and the relevance or otherwise on the need for any further initial investigation.

For cases involving the Medical Director, the Chief Executive will be the Case Manager. For cases involving Clinical Directors, a Senior Clinical Director Deputy Medical Director, or the Medical Director will be the Case Manager. For all other medical staff, the Case Manager will be a Clinical Director, Senior Clinical Director or Director of Operations.

The duty to protect patients is paramount. At any point in the process where the Case Manager has reached an initial judgement that a doctor is considered to be a potential danger to patients or staff, that doctor must be referred to the GMC, and the DMG, whether or not the case has been referred to the NCAS, and in addition, consideration must be given as to whether the issue of an alert letter should be requested.

When serious concerns are raised about a doctor, the DMG will also 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 the Exclusion of the doctor from the work place.

All serious concerns must be investigated quickly and appropriately and a clear audit route established for initiating and tracking progress of the investigation and resulting action. The concerns will be registered with the Chief Executive. The Chair of the Trust will appoint a Designated Board Member to oversee the case and ensure that momentum is maintained.

5.2 Restrictions of practice and exclusion from work

When serious concerns are raised about a doctor, the DMG will urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the doctor from the workplace.

The DMG must ensure that:

- exclusion from work is used only as an interim measure whilst action to resolve a problem is being considered;
- where a doctor is excluded, it is for the minimum necessary period of time and not more than four weeks without further review;
- A brief report of any exclusion will be provided to the Chief Executive and Board of Directors
- A detailed report is provided when requested to the Designated Board Member who will be responsible for monitoring the situation until the exclusion has been lifted.

5.2.1 Managing the risk to patients

Exclusion of a doctor from the workplace is a temporary expedient. Exclusion must be viewed as a precautionary measure and not a disciplinary sanction. Exclusion from work will be reserved for the most serious circumstances.

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 doctor's presence could impede the gathering of evidence.
- To protect the doctor

5.2.2 Alternative ways to manage risks and avoid exclusion

Consideration will always be given to alternative ways that can be used to avoid exclusion. These include:

- The feasibility of the Medical Director or a Clinical Director supervising the doctor’s normal contractual clinical duties;
- Restricting the doctor to specified clinical duties;
- Restricting the doctor's 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 if the doctor has a specific health problem.

In cases relating to the capability of a doctor, consideration should be given to whether an action plan to resolve the problem is appropriate having regard to the seriousness of the concern and whether it can be agreed with the doctor. If the nature of the problem and a workable remedy cannot be determined in this way, the Case Manager should seek advice from and consider the appropriateness of a referral to NCAS. They will assess the problem in more depth and give advice on any action necessary.

5.2.3 The exclusion process

The DMG cannot exclude the doctor for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis by the DMG and before any further four-week period of exclusion is imposed.

There are two forms of exclusion: formal and immediate exclusion.

5.2.4 Key responsibilities of managing exclusion

The DMG has overall responsibility for managing the exclusion procedures and for ensuring that cases are properly managed. In the rare cases where immediate exclusion is required, the DMG must discuss the case at the earliest opportunity following exclusion.

The doctor will be promptly informed of any decision to exclude by either the Medical Director or Deputy Medical Director and representative from Medical Development. Where this is not possible, a Locality Director or Senior Clinical Director may inform the doctor of the decision made. The nominated person must explain why the exclusion is being made and this may need to be in broad terms if no formal allegation has been made at this stage. They will agree a date up to a maximum of two weeks away at which the doctor should return to the workplace for a further meeting. The nominated person must advise the doctor of their rights, including rights of representation to the Designated Board Member.

The DMG will ensure a Case Manager is appointed following exclusion if one has not already been appointed. The DGM will also ensure a Case Investigator is appointed.

5.2.5 Role of Designated Board Member

Representations may be made to the Designated Board Member in regard to exclusion. The Designated Board Member must ensure that time frames for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights.

5.2.6 Immediate exclusion

An immediate time limited exclusion may be necessary where there has been

- a critical incident when serious allegations have been made; or
- there has been a break down in relationships between a doctor and all or a significant proportion of the medical team; or
- the presence of the doctor is likely to hinder the investigation.
- for the doctors own protection

Such exclusion will allow more measured consideration to be undertaken. This period should be used to carry out a preliminary situation analysis, to contact NCAS for advice and to convene a DMG if one has not already been convened.

5.2.7 Formal exclusion

Formal exclusion may only take place after the DMG has first considered whether there is a case to answer and whether there is reasonable and proper cause to exclude. NCAS must be consulted where formal exclusion is being considered and 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 DMG. This preliminary report is advisory to enable the DMG to decide on the next steps as appropriate.

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

- the allegation appears unfounded: or
- there is a potential misconduct issue;
- or there is a potential concern about the doctor's capability; or
- the complexity of the case warrants further detailed investigation
- exclusion is required for the doctors own protection

Formal exclusion 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,
   - For the doctor's own protection

(b) The presence of the doctor in the workplace is likely to hinder the investigation.

Full consideration should be given as to whether the doctor 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.

When the doctor 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 doctor. The doctor 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 doctor should be given the opportunity to state their case and propose alternatives to exclusion (e.g. further training, referral to Occupational Health, referral to the NCAS with voluntary restriction).

Formal exclusion must be confirmed in writing as soon as is reasonably practicable with the letter stating the effective date and time, duration (up to 4 weeks), the broad nature of the allegations, the terms of the exclusion (e.g. exclusion from the premises and the need to remain available for work) and that a full investigation or what other action will follow. The doctor 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.

In cases when disciplinary or capability procedures are being followed, exclusion may be extended for four-week renewable periods until the completion of the procedures if a return to work is

considered inappropriate. The exclusion will still only last for four weeks at a time and be subject to review. The exclusion should usually be lifted and the doctor allowed back to work, with or without conditions placed upon the employment, as soon as the original reasons for exclusion no longer apply.

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

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

5.2.8 Exclusion from premises

A doctor should not be automatically barred from the premises upon exclusion from work. The Case Manager must always consider whether a bar from the premises is absolutely necessary. There are certain circumstances, however, where the doctor should be excluded from the premises. This could be, for example, where there may be a danger of tampering with evidence, or where the doctor may be a serious potential danger to patients or other staff or from patients or other staff. In other circumstances, however, there may be no reason to exclude the doctor from the premises. The doctor 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.

The Case Manager should consider whether it is appropriate to make arrangements for the doctor to 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 in the Trust. A mentor could also be appointed for this purpose if a colleague is willing to undertake this role.

5.2.9 Keeping in contact and availability for work

As exclusion under this policy should be on full pay, the doctor must remain available for work with the Trust during their normal contracted hours. The doctor 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. Consent is required from the Case Manager if the doctor wishes to take annual leave or study leave. Failure to abide by these conditions will lead to suspension of salary and disciplinary action.

5.2.10 Informing other organisations

In cases where there is concern that the doctor may be a danger to patients, the Case Manager 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. Where restrictions on

practice have been placed on the doctor, the doctor may offer to undertake not to perform any work in that area of practice with any other employer. In such circumstances the Case Manager should take such an undertaking into account in deciding whether it is necessary to inform other organisations.

Where the Case Manager believes that the doctor is practising in breach of an undertaking not to do so, he or she should contact the GMC and NCAS to consider the issuing of an alert letter. This is in addition to any further action the Case Manager may decide is appropriate including a disciplinary investigation and a referral to the DMG to consider whether Exclusion is appropriate

5.2.11 Keeping Exclusions under review

Informing the Board

The Chief Executive and Board must be informed about exclusion at the earliest opportunity. The Board has a responsibility to ensure that the Trust's internal procedures are being followed. The Medical Staffing team will:

- provide a summary of the progress of each case together with a monthly statistical summary showing all exclusions with their duration and number of times the exclusion had been reviewed 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;

Regular review

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 doctor 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 doctor will be entitled to return to work at the end of the four-week period if the exclusion is not actively reviewed.

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 doctor, and/or the needs of the investigative process continue to necessitate exclusion and give full consideration to the option of the doctor returning to limited or alternative duties where practicable.

The Chief Executive and the Board will review exclusion before the end of each 4-week period and after three exclusions, NCAS will be called for any appropriate advice and the Designated Board Member informed.

The next section outlines the activities that must be undertaken at different stages of exclusion.

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

Before the end of each exclusion (of up to 4 weeks,) the Case Manager must review the position.

- The Case Manager decides on next steps as appropriate, taking into account any views of the doctor. Further renewal may be for up to 4 weeks;
- The Case Manager submits an advisory report of outcome to Chief Executive and the Trust Board. 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.
- Each renewal is a formal matter and must be documented as such;
- The doctor must be sent written notification on each occasion.

If the Doctor has been excluded for three periods:

- A report must be made to the Chief Executive and Board outlining the reasons for the continued exclusion, 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 Chief Executive must report to NCAS and the Designated Board member.
- The report must formally explain:
    - why continued exclusion is appropriate
    - what steps are being taken to conclude the exclusion, at the earliest opportunity;

6 months review

If the exclusion is likely to be extended over six months a further report must be made by the Chief Executive to NCAS outlining:

- the reason for continuing the exclusion;
- anticipated time scale for completing the process;
- actual and anticipated costs of exclusion.

NCAS 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.

Normally there should be a maximum limit of 6 months exclusion, except for those cases involving criminal investigations of the doctor concerned. The Trust and NCAS will actively review those cases at least every six months. When an exclusion decision has been extended for 12 months in total, the Chief Executive must inform NCAS of what action is proposed to resolve the situation. This should include dates for hearings or give reasons for the delay.

5.2.12 The role of the Board and Designated Board Member

The Board is responsible for designating one of its non-executive members as a Designated Board Member under these procedures.

The Designated Board Member's responsibilities include:

- Receiving reports and reviewing the continued exclusion from work of the doctor;
- Considering representations from the doctor about his or her exclusion;
- Considering any representations about the investigation;

5.2.13 Returning to Work

If it is decided that the exclusion should come to an end, there must be formal arrangements for the return to work of the doctor. 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.

5.2.14 Doctor facing conduct or capability proceedings becoming unwell

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

If, in exceptional circumstances, a hearing proceeds in the absence of the doctor, the doctor will have the opportunity to submit written submissions and/or have a representative attend in his or her absence.

5.3 The Case Manager and Case Investigator

5.3.1 Case Manager

The Case Manager will normally be the Clinical Manager appointed by the DMG. If the Clinical Manager has been extensively involved in the concern or is likely to be interviewed by the Case Investigator on any matter of substance, the DMG will appoint an alternative Case Manager.

The Case Manager is responsible for ensuring that the investigation is conducted fairly and efficiently and they will ensure that they:

- Act as a co-ordinator between the doctor, the Case Investigator and others interviewed.
- Ensure confidentiality, proper documentation of the process and ensure access to any documentation required by the Case Investigator.
- Ensure the doctor and witnesses have appropriate support.
- Have no conflict of interest or appearance of bias.
- Are not involved in the investigation detail itself.
- Write the terms of reference for the Case Investigator.
- Discuss the case with NCAS

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

NCAS can also undertake a formal clinical performance assessment when the doctor, the Case Manager and NCAS agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps.

5.3.2 Appointing a Case Investigator

An appropriately experienced or trained person will be appointed by the DMG as the Case Investigator.

The Case Manager will draft the terms of reference for the case that will be given to the Case Investigator. A member of the Medical Development team will support the drafting of this document.

The terms of reference may include:

- Issues to be investigated
- Boundaries of the investigation
- List of likely witnesses to be interviewed
- Period under investigation
- Timescale for completion of investigation and submission of a report

The doctor concerned must be informed promptly in writing by the Case Manager, when it has been decided that an investigation is to be undertaken, the name of the Case Investigator and provided with a copy of the terms of reference. He should be provided with the name of a support doctor in accordance with appendix 8. The doctor should also be provided with a copy of this policy and advised the doctor cannot leave the country without the prior consent of the Case Manager. The doctor must be given the opportunity to see any documents if the doctor so requests relating to the case prior to any interview. The doctor must also be afforded the opportunity to put their view of events to the Case Investigator and given the opportunity to be accompanied by the Doctor's Companion at any such meeting.

5.3.3 The role of Case Investigator

The Case Investigator will be responsible for leading the investigation into the allegations or concerns about a doctor, establishing the facts and reporting the findings. A checklist outlining the key responsibilities of the role is in appendix 1.

The Case Investigator:

- must formally involve the Clinical Adviser where a question of clinical judgment is raised during the investigation process. Where no other suitable senior doctor is employed by the Trust, a senior doctor from another Trust should be involved.
- must ensure that confidentiality is respected whilst ensuring that the doctor is aware of the case the doctor has to meet.
- must ensure that a written record is kept of the investigation.
- must co-operate with the Designated Board Member if required to do so.

Ensure that evidence that may be supportive as well as unsupportive of the doctor is gathered

The Case Investigator will not make the decision on what action should be taken.

At any stage of this process or subsequent disciplinary action the doctor may be accompanied in any interview or hearing by the Doctors Companion.

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.

In situations where further concerns or evidence is identified, the Case Investigator will inform the Case Manager and a decision taken as to whether the terms of reference should be amended.

The Case Investigator should attempt to complete the investigation within 8 weeks of appointment and submit their report to the Case Manager within a further 5 working days. Any extension must be agreed by the Case Manager and the doctor informed of this extension in writing.

In cases where the doctor admits the allegations and provides a written statement to this effect, then it may be possible to go straight to a determination by the Case Manager without the need for a full investigation. However the Case Manager must always seek advice from Medical Development in such cases as even where an individual admits the allegations it may still be necessary to carry out a full investigation.

If whilst under investigation an individual becomes unwell and subsequently goes on sick leave, the investigation will continue whilst advice is obtained from Occupational Health as to whether the individual is fit to participate. The Case Manager will bear in mind that the question is not whether the doctor is fit for work but whether the doctor is fit to attend an investigatory meeting.

The Case Manager may give consideration to allowing the doctor to answer questions in writing if the doctor is unfit to attend an investigatory and, if necessary, a disciplinary meeting.

In considering any adjournments, the Case Manager will bear in mind the need to conclude the investigation promptly whilst permitting the doctor the opportunity to put forward the doctor's explanation.

5.3.4 Writing the report

The report of the Case Investigator should give the Case Manager sufficient information to make a decision whether the case should be referred to a panel.

The report template, appendix, must be used as the structure to present the findings.

5.3.5 Determining the next steps

Before making a decision whether the case should be referred to a panel the Case Manager must give the doctor the opportunity to comment in writing on the factual content of the report produced by the Case Investigator. Comments in writing from the doctor, including any mitigation, must be submitted to the Case Manager within 10 working days of the date of receipt of the request for comments. In exceptional circumstances the deadline for comments from the doctor may be extended.

The Case Manager should decide what further action is necessary, if any, taking into account the findings of the report, any comments that the doctor has made and any advice from NCAS. The options include:

- Develop a remediation plan
- Formal hearing
- The report and/or comments from the doctor now require restrictions on practice or exclusion from work.
- No action to be taken

If it is felt that the situation warrants remediation then an action plan will be developed and this will be documented appropriately and copies placed on personal files and recorded on the central system in Medical Development. The Case Manager will inform the doctor of the decision. If at any point of a remediation action plan being in place, a doctor fails to achieve the standards and improvements required, the case will be treated as a serious concern being returned back to the formal procedures to be followed as detailed in the flow chart.

There may be occasions when a case has been considered by NCAS, but the advice of its assessment panel is that the doctor'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 NCAS advice, whether the case should be determined under the capability procedure.

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

5.3.6 Procedure to establish a hearing

- The Case Manager must notify the doctor in writing of the decision to arrange a panel hearing. This notification should be made at least 20 working days before the hearing and include details of the allegations, the Case Investigators report, and the doctors statement, if any. The letter should set out the date, time and venue of the hearing plus who will be on the panel and the witnesses the Trust will call (unless their identity should be protected). The doctor should be advised of the right to be accompanied by the Doctor's Companion.
- The doctor must supply copies of any documentation, including witness statements, on which the doctor wishes to rely no later than 10 working days before the hearing together with information as to the identity of the Doctor's Companion and any witnesses, that the doctor intends to call.
- Witnesses who have made written statements at the inquiry stage may, but will not necessarily, be required to attend the hearing unless either party notifies the other in good time of the need for their attendance. 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.

5.3.7 Confidentiality

The Trust will maintain confidentiality at all times. No press notice will be issued, nor the name of the doctor released, in regard to any investigation or hearing into disciplinary matters. The Trust will only confirm publicly that an investigation or disciplinary hearing is underway.

Personal data released to the Case Investigator for the purposes of the investigation must not be disproportionate to the seriousness of the matter under investigation. The Trust will operate consistently with the guiding principles of the Data Protection Act.

5.4 The hearing framework

Once it has been determined that there is a case to answer, the allegations will generally be either concerns of conduct or capability. It is possible however those allegations may contain issues relating to both conduct and capability.

5.4.1 Dealing with matters of conduct

The Trust has developed a 'Compact' and has established shared values and behaviours that it expects from all staff. This sets out acceptable standards of conduct and behaviour expected. Similar expectations are set out by the GMC and are outlined in the GMC 'Good Medical Practice' and 'Good Doctors, Safer Patients' and lapses are considered to be "misconduct".

Misconduct can cover a very wide range of behaviour. Examples of misconduct will vary greatly and are outlined in appendix 3. 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.

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.

It is for the Trust to decide upon the most appropriate way forward, and this may include guidance from NCAS and an employment law specialist.

5.4.2 Action when investigations identify possible criminal acts

Where an investigation establishes a suspected criminal action in the UK or abroad this must be reported to the police. The Case Manager will decide, based on the circumstances, whether to proceed, considering whether an investigation would impede a police investigation. In cases of fraud, the Counter Fraud & Security Management Service must be contacted.

5.4.3 Dealing with matters of capability

The causes of adverse events should not automatically be attributed to the actions, failings or unsafe acts of an individual alone.

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

5.4.4 Hearing Panel composition

The procedure for capability and conduct concerns will follow the same format and process but panel members will differ as outlined below:

Issues of conduct

- One of either the Medical Director/Deputy Medical Director/Director of Operations (Chair and Determining Manager)
- A doctor of the same specialty as the doctor under investigation not employed by the Trust (professional conduct matters only. This member is excluded if the case is one of personal misconduct) as a non-voting advisor.
- The panel will be supported by a non-voting member of medical staffing or HR.

Issues of capability concerns

- One of either the Medical Director/Deputy Medical Director/Senior Clinical Director
- Director of Operations
- A non-executive director of the Trust.
- A medically qualified member who is not employed by the Trust. In the case of clinical academics, a further panel member may be appointed in accordance with any protocol agreed between the Trust and the University.

The Panel will determine the outcome collectively, if necessary by majority vote. The panel will be supported by a non-voting member of medical staffing or HR.

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.

5.4.5 Failure to attend a hearing

If the doctor fails to attend a hearing, reasonable steps should be taken to establish the reason and, in the absence of any justifiable reason, the panel retains the right, to proceed with the hearing in the doctor’s absence if in the panel's opinion it is reasonable to do so.

Should the doctor’s ill health be such the panel's decides the hearing will be adjourned the Trust will implement its usual absence procedures and involve Occupational Health.

Multiple adjournments should not be permitted and if the doctor is unable to attend the hearing due to, for example, ill health, consideration should be given to other methods to permit the doctor to make representations on the evidence, for example a written statement.

If evidence is contested and the witness is unable or unwilling to attend, the panel should consider reducing the weight given to the evidence.

5.4.6 The procedure at the hearing

The hearing should be conducted as follows:

- The Panel (and its advisers as necessary), the doctor, the Doctor's Companion and the Case Manager will be present at all times (save in exceptional circumstances) during the hearing.

Witnesses will be admitted only to give their evidence and answer questions and will then retire.

- The Chair of the panel will be responsible for the proper conduct of the proceedings. The Chair should introduce all persons present and announce which witnesses are available to attend the hearing.
- The Chair will inform everyone at the hearing that the use of digital recording is not permitted.
- In the event of late evidence being presented, the Panel should consider whether to admit the same or not and if it is to be admitted wholly or in part whether the hearing should also be adjourned to allow the other party adequate time to prepare.
- 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 procedure for dealing with any witnesses attending the hearing shall be the same and shall reflect the following:

5.4.7 Order of presentation

The Case Manager presents the management case including the calling of any witnesses. The procedure for dealing with witnesses shall be undertaken for each witness in turn and at the end of this each witness shall be allowed to leave.

- The witness shall confirm any written statement and give any supplementary evidence.
- The side calling the witness can question the witness.
- The other side can then question the witness.
- The panel may question the witness
- The side which called the witness may seek to clarify any points which have arisen during questioning but may not raise new evidence.
- The Chair shall invite the Case Manager to clarify any matters arising from the management case on which the panel requires further clarification.
- The doctor and/or the Doctor's Companion shall present the doctor’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 Chair shall invite the Case Manager to make a brief closing statement summarising the key points of the case.
- The Chair shall invite the doctor and/or the Doctor's Companion to make a brief closing statement summarising the key points of the doctor’s case. Where appropriate this statement may also introduce any grounds for mitigation.

The Panel shall then retire to consider its decision. The Panel if it thinks fit may recall any witness or require other evidence to be produced to it but both parties must be given adequate time to consider any such evidence. The Panel will deliberate in private only recalling both parties to clear points of uncertainty on evidence already given.

5.4.8 Decision

The Panel has the power to make a range of decisions including the following:

- No action required

- Remediation is necessary.
- Written warning (coupled with an improvement plan setting out a specified time scale with a statement of what is required and how it might be achieved in cases of capability).
- Final written warning (coupled with an improvement plan setting out a specified time scale with a statement of what is required and how it might be achieved in cases of capability).
- Termination on notice
- Termination forthwith for gross misconduct

Before deciding what form of action should be taken, if any, the Panel should consider:
- The employees live disciplinary record and;
- Any mitigating circumstances which make it appropriate to lessen the severity of the penalty; and
- The action taken in similar cases in the past; and whether the proposed action is reasonable in the circumstances

A record of remediation agreements and written warnings should be kept on the doctor’s personnel file but should be removed after the specified period.

The decision of the Panel/Determining Manager should be communicated to the parties as soon as possible and normally within 5 working days of the hearing.

The decision must be confirmed in writing to the doctor. The document will include:

- the allegations against the doctor
- the decision(s) of the Determining Manager/Panel
- the reasons for the decision
- the disciplinary sanction imposed and the rationale for the level of sanction
- the timescale over which the disciplinary action is effective if appropriate
- any special conditions applying to the disciplinary action, e.g. in cases of poor performance an action plan setting out the improvements that are expected, timescales for improvements, supervision requirements, review periods
- the consequences of any further misconduct/failure to improve performance to a satisfactory level.
- notification that the details of the disciplinary action taken will be retained on file
- notification of the right of appeal against the decision in accordance with section 7 of this policy and procedure.

5.5 The appeals procedure

5.5.1 The appeal process

Where the appeal is against dismissal, the doctor should not be paid from the date of dismissal until the determination of the appeal Should the appeal be upheld, the doctor should be reinstated and must be paid backdated to the date of termination of employment less any payments the doctor has received in the interim.

5.5.2 Grounds of appeal

The Panel has power to consider an appeal on none or more of the following grounds:

The penalty was excessive

- All or part of the allegations should not have been found proven
- There was a breach of policy that materially affected the outcome
- New evidence has become available that was not reasonably available at the time of the hearing and it would have materially affected the outcome.

5.5.3 Timing of the appeal

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

- Appeal by written statement to be submitted to the Associate Director of Medical Development within 25 working days of the date of the written confirmation of the original decision. Any appeal raised should clearly identify the reasons for requesting an appeal
- The Trust will use its best endeavours to ensure the appeal hearing takes place within 25 working days of date of lodging appeal.
- The appeal outcome will be communicated to the doctor within 5 working days of the conclusion of the hearing.

Any application for any extension of time must be made to the Chair of the Panel.

5.5.4 The Appeal Panel

The Panel will consist of three members.

- The Chair or Deputy Chair of the Trust
- A non-executive director of the Trust who has not been previously involved.
- A doctor of the same specialty as the doctor appealing but not employed by the Trust.

The Panel will be supported by a non-voting member of medical staffing or HR.

5.5.5 Powers of the Appeal Panel

The appeal Panel has the right to call witnesses of its own volition, but will notify both parties at least 10 working days in advance of the hearing and provide them with a written statement from any such witness at the same time.

Exceptionally, where during the course of the hearing the appeal Panel determines that it needs to hear the evidence of a witness not called by either party, then it shall have the power to adjourn the hearing to allow for a written statement to be obtained from the witness and made available to both parties before the hearing reassembles.

If, during the course of the hearing, the appeal Panel determines that new evidence needs to be presented, it should consider whether an adjournment is appropriate. Much will depend on the weight of the new evidence and its relevance.

5.5.6 Conduct of appeal hearing

The format of the appeal hearing will mirror that of the hearing itself.

The doctor may be represented.

The Panel shall consider and make its decision in private.

5.5.7 Decision

The decision of the appeal Panel shall be in writing to the doctor and shall be copied to the Case Manager normally within 5 working days of the conclusion of the hearing.

- The appeal Panel will determine one or a combination of the following decisions:
- That the original decision(s) was correct
- That the original decision (s) was not correct
- That the original decision(s) was not appropriate, and impose a lesser sanction.
- That the original decision was not appropriate and impose a higher sanction.
- That the original decision(s) was not appropriate, and withdraw the sanction.

The decision of the appeal Panel is final.

5.5.8 Action following hearing

Records will be kept, including a report detailing the capability or conduct issues, the doctor's defence or mitigation, the action taken and the reasons for it. These records must be kept confidential and retained in accordance with this document and the Data Protection Act 1998. These records need to be made available to those with a legitimate call upon them, such as the doctor, any Regulatory Body, or in response to a direction from an Employment Tribunal.

5.5.9 Termination of employment with performance issues unresolved

Where a doctor leaves employment before disciplinary procedures have been completed, the investigation must be completed wherever possible whatever the personal circumstances of the doctor concerned.

Every reasonable effort must be made to ensure the doctor remains involved in the process. If contact with the doctor has been lost, the Case Manager will invite them to attend any hearing by writing to their last known home address. The Determining Manager or Panel will make a judgement, based on the evidence available, as to whether the allegations about the doctor's conduct or capability are upheld.

5.6 Handling concerns about a doctor's health

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

The principle for dealing with doctors with health problems is that, wherever possible and consistent with reasonable public protection, they should be treated, rehabilitated or re-trained and kept in employment, rather than be lost from the NHS.

5.6.1 Retaining the services of doctors with health problems

At this stage, the Trust sickness absence procedure will be followed and a referral made to the Occupational Health Service to gain advice. The outcomes may include:

- sick leave for the doctor
- remove the doctor from certain duties;
- reassign the doctor to a different area of work;
- arrange re-training or adjustments to their working environment, with appropriate advice from the NCAS and/or deanery, and /or under the reasonable adjustment provisions in the Equality Act 2010

5.6.2 Reasonable adjustments

At all times the doctor will be supported by the Trust and the Occupational Health Service who should ensure that the doctor is offered reasonable resources to get back to practise where appropriate. The Trust should consider what reasonable adjustments could be made to their workplace or other arrangements.

5.6.3 Examples of reasonable adjustment

- Making adjustments to the premises;
- Re-allocate some of the doctors duties to another;
- Transfer a doctor to an existing vacancy;

- Alter the doctor's working hours or pattern of work;
- Assign the doctor to a different workplace;
- Allow the doctor absence for rehabilitation, assessment or treatment;
- Provide additional training or retraining;
- Acquire/modify equipment;
- Modifying procedures for testing or assessment;
- Providing a reader or interpreter;
- Establish mentoring arrangements.

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 this is appropriate.

5.6.4 Handling health issues

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

NCAS should be approached to offer advice on any situation and at any point where the Trust is concerned about a doctor.

A referral to the Occupational Health physician should be made by the Clinical or Case Manager. Confidentiality must be maintained by all parties at all times.

If a doctor'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 and referral to the professional regulatory body must be undertaken, irrespective of whether or not they have retired on the grounds of ill health.

In those cases where impairment of performance is solely due to ill health, formal procedures will be considered only in the most exceptional of circumstances, for example if the individual concerned refuses to co-operate with the Trust to resolve the underlying situation e.g. by repeatedly refusing a referral to Occupational Health or NCAS. In these circumstances the Trust will continue to move through the relevant stages outlined in this procedure.

There will be circumstances where a doctor who is subject to disciplinary proceedings puts forward a case, on health grounds, that the proceedings should be delayed, modified or terminated. In such cases the Trust is expected to refer the doctor to the Occupational Health service for assessment as soon as possible. Unreasonable refusal to accept a referral to, or to co-operate with, the Occupational Health service under these circumstances, may give separate grounds for pursuing disciplinary action.

5.7 Guidance on agreeing terms of reference for settlement on termination of employment

In some circumstances, terms of settlement may be agreed with a doctor 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 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 be able to stand up to district auditor and public scrutiny. Approval prior to any settlement must be obtained from the appropriate authorities.

- Offers of compensation, as an inducement to secure the voluntary resignation of 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. Any Settlement Agreement should not include the provision of an open reference.
- A Settlement Agreement must not include clauses intended to cover up inappropriate behaviour or inadequate services.
- Where a settlement is agreed, details must be recorded with Medical Staffing.

6 Definitions

Term	Definition
Doctor's Companion:	The chosen companion may be a fellow worker, a trade union representative, an official employed by a trade union or Professional Organisation. A trade union representative who is not an employed official must have been certified by their union as being competent to accompany a worker. A fellow worker must be an employee of the Trust. The Doctor's Companion may address the hearing in order to present the doctor's case, question witnesses, sum up the doctor's case and respond on the doctor's behalf to any view expressed at the hearing. The Doctor's Companion may not answer questions on behalf of the doctor.
Counselling by the Manager	An informal discussion with the objective of encouraging and helping the doctor to improve.
Decision Making Group (DMG)	The DMG will assess the level of concern and make a preliminary decision on category and level, and what action should follow, including commissioning of an investigation, remediation and/or restriction of practice.
Clinical Manager	A person to whom initial concerns identified about a doctor in their team should be reported. A Clinical Manager looks into the case and where necessary gathers facts in order to make an initial judgement.
Case Manager	A person assigned to ensure that all allegations or concerns are properly investigated.
Case Investigator	A person assigned to lead the investigation into the allegations or concerns, establishing the facts and reporting findings.
Clinical Advisor	A person suitable medically qualified to support the Case Investigator in relation to concerns of a clinical nature.
Designated Board Member	A non-executive director appointed by the Trust Chair to oversee the case and ensure momentum is maintained and to review, if requested, any Exclusion.
Determining Manager	A manager (not the Clinical Manager) appointed to make a decision at a hearing after hearing evidence from both parties.
Exclusion	The procedure where the Trust requires the doctor to refrain from attending work for a period of time while the investigation proceeds and where there is no other viable alternative in the reasonable opinion of the Trust.
Disciplinary Sanction	Action imposed after a formal disciplinary meeting.
Spent	When a disciplinary sanction has passed the period of time that it is 'live' and therefore should be disregarded in relation to determining the level of any future disciplinary action.

Remediation	A process to support the management of concerns. i.e. the act of correcting behaviour or skills deficits which would include, but not limited to, concerns arising from assessment, review or appraisal. Remediation is not a disciplinary sanction.

7 Related documents

Health and Safety Policy

Grievance Procedure

Whistle Blowing Policy

8 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

9 How this policy will be audited

This policy and procedure will be kept under review and any amendments to it will be made only after consultation with the Local Negotiating Committee unless changes are required by legislation, Government or Regulator requirements. The operation of the procedure will be reviewed after three years. The policy and procedure will remain in force until reviewed.

10 References

GMC Fitness to Practice

DH Tackling Concerns Locally

The Medical Profession (Responsible Officers) Regulations 2010

NCAS Handling concerns about a Doctor's behaviour and conduct

NCAS Handling concerns about doctors' health

NCAS How to conduct a local performance investigation

NCAS Back on track framework for further training

NCAS Handling performance concerns in primary care

NCAS Professionalism - dilemmas and lapses

NCAS Handling Concerns about the Performance of Healthcare Professionals

NCAS Understanding Performance Difficulties in Doctors

NCAS What to do if you have concerns about a colleague's performance

NHS England Guidance on Revalidation

11 Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Medical Directorate					
Name of responsible person and job title	Bryan O'Leary, Associate Director of Medical Development					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	LNC Representatives					
Policy (document/service) name	Medical Remediation and Disciplinary Policy					
Is the area being assessed a;	Policy/Strategy	✓	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state					
Geographical area	Trust wide					
Aims and objectives	To provide clarity on investigation process for medical staff. To outline the full medical disciplinary operational procedure.					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	November 2016					
End date of Equality Analysis Screening (This is when you have completed the analysis and it is ready to go to EMT to be approved)	November 2016					

You must contact the EDHR team as soon as possible where you identify a negative impact. Please ring Sarah Jay or Tracey Marston on 0191 3336267/3542

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Medical Staff and Mangers of Medical Staff					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Gender** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No
Yes – Please describe anticipated negative impact/s **No** – Please describe positive impacts/s					

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not? National agreed procedure maintaining high professional standards has to be followed.**	**Yes**		**No**	✓

Sources of Information may include:

- Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc.
- Investigation findings
- Trust Strategic Direction
- Data collection/analysis
- National Guidance/Reports
- Staff grievances
- Media
- Community Consultation/Consultation Groups
- Internal Consultation
- Research
- Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership
Yes – Please describe the engagement and involvement that has taken place
LNC BMA
No – Please describe future plans that you may have to engage and involve people from different groups

<table>
<tr><td colspan="6">5. As part of this equality analysis have any training needs/service needs been identified?</td></tr>
<tr><td>No</td><td colspan="5">Please describe the identified training needs/service needs below</td></tr>
<tr><td colspan="6">A training need has been identified for;</td></tr>
<tr><td>Trust staff</td><td>Yes/No</td><td>Service users</td><td>Yes/No</td><td>Contractors or other outside agencies</td><td>Yes/No</td></tr>
<tr><td colspan="6">Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so</td></tr>
<tr><td colspan="5">The completed EA has been signed off by:
You the Policy owner/manager:
Type name: Bryan O’Leary</td><td>Date:
08.11.2016</td></tr>
<tr><td colspan="5">Your reporting (line) manager:
Type name: Dr Nick Land</td><td>Date:
08.11.2016</td></tr>
<tr><td colspan="6">If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/6542 or email: traceymarston@nhs.net</td></tr>
</table>

12 Document control

Date of approval:	7 December 2016	
Next review date:	01 February 2022	
This document replaces:	Medical Disciplinary Policy and Procedure HR/0008/v2	
Lead:	Name	Title
	Bryan O'Leary	Associate Director of Medical Development
Members of working party:	Name	Title
This document has been agreed and accepted by: (Director)	Name	Title
	Dr Nick Land	Medical Director
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	7 December 2016
An equality analysis was completed on this document on:	8 November 2016	

Change record

Version	Date	Amendment details	Status
V4	7 Dec 2016	Full review	Published
V4	13 Nov 2019	Review date extended from 07 Dec 2019 to 07 Feb 2020	Published
V4	19 Feb 2020	Review date extended from 07 Feb 2020 to 31 Aug 2020	Published.
V4	18 Jun 2020	Review date extended from 31 August 2020 to 28 Feb 2021	Published
V4	05 Feb 2021	Review date extended by six months to 31 Aug 2021	Published
V4	02 Aug 2021	Review date extended to 01 Feb 2022	Published

Appendix 1 - Checklists to support roles

- Clinical Manager
- Case Manager
- Case Investigator
- Determining Manager
- Designated Board Member & Chief Executive

Role of Clinical Manager:

Step 1 – Immediate Action	
Upon receipt of an allegation/complaint/concern, a decision will be taken as to whether it is felt this should be looked at further. This should be done in consultation with Medical Development. A short fact find may or may not be necessary.	
If no further action required, write file note and pass to Medical Development for central recording.	
If it is deemed low level concerns – meet with doctor to discuss further and set an action plan with clear targets and timescales. Copy of action plan to be sent to Medical Development for monitoring.	
Set up a further meeting to review action plan at the end of the timescales set. If action plan not met, Clinical Manager must consider next steps (see section 3)	
If it is deemed a serious concern it must be raised with Medical Development ASAP who will convene a DMG (Go to Step 3)	
Step 2 – DMG	
The DMG will decide whether a formal investigation is required, whether further facts need to be gathered or whether medical remediation is appropriate or indeed whether the matter should have been closed at the point of the case discussion.	
Consider whether Exclusion or restrictions to practice are necessary.	
If no further action is required, a file note must be written and forwarded to Medical Development for records.	
If remediation is required, follow section 3 titled low level concerns.	
If concerns are serious, follow section 4 and remember that NCAS involvement must be considered at this point.	
Step 3 – Formal Investigation	
The DMG will identify an appropriate Case Manager for the formal investigation This will normally be the Clinical Manager.	
If the Clinical Manager is unable to be Case Manager (for example the Clinical Manager may be an important witness of fact in any subsequent investigation then the Clinical Manager should make arrangements to brief the Case Manager.	
The DMG will identify an appropriate Case Investigator.	
Should the concerns be of a clinical nature, a 'Clinical Advisor' will be identified by the DMG to support the Case Investigator.	

Role of Case Manager:

Step 1 – Immediate Action	
The Case Manager will be given a brief from the Clinical Manager, if it is not the same person, or from the DMG.	
If immediate exclusion is in place, ensure a preliminary situation analysis is carried out so next steps are understood.	
If formal exclusion, ensure that the Case Investigator provides a preliminary report as soon as possible, to allow the Case Manager to produce progress reports for the Board and Designated Board Member.	
Discuss the case with NCAS and whether an informal approach can be taken to address the problem.	
Write and agree terms of reference for the Case Investigator to follow (see 4.4). This will be formed by the allegation/s and will be written with the support of Medical Development. The terms of reference will also include a clear audit route established for initiating and tracking progress of the investigation.	
Create a time line for key stages and decisions in the process.	
Ideally the Case Investigator will discuss the case with the Case Manager at two weekly intervals. At this point and throughout the investigation, consideration should be given to whether Occupational Health support is necessary.	
Step 2 – Write to the Doctor	
Give the names of the Case Investigator and the Designated Board Member (where applicable)	
Provide a copy of the terms of reference.	
Provide copy of medical remediation and disciplinary procedure	
Provide details of the access to counselling service and Occupational Health and the name of a support doctor as set out in appendix 8.	
Advise the doctor they can’t leave the country without the Case Manager's consent (which will not be unreasonably withheld).	
Investigation Report	
The investigation should be completed within 8 weeks of notifying the doctor of the allegations/concerns/complaint.	
The investigation report should be produced within 5 working days from completion of investigation.	
Upon receipt of the investigation report, but before making a decision, the Case Manager must give the doctor the opportunity to comment in writing on the factual content of the report produced.	
Step 3 – Determining the Next Steps	

Case Manager must then decide what further action is necessary, taking into account the findings of the report, comments from doctor and any advice from NCAS. Options could include to develop a remediation plan; a formal hearing; restrictions on practice, Exclusion from work pending a formal hearing or no action to be taken. (Full details in 6.6)	
Step 4 – Prior to Hearing	
Write to doctor to confirm arrangements for hearing and attach copy of investigation report and the doctor's statement (if any). (Medical development will draft the letter). The letter must set out the date and time and venue of the hearing, who will be on the hearing panel, the witnesses the Trust will call and the doctor's right to be accompanied by the Doctor's Companion	
Case files should be submitted at least 20 working days before the Hearing.	
Details to include; date, time, venue and who will be in attendance and their roles at the meeting.	
Doctor must be told of the right to be accompanied by the Doctor's Companion.	
Step 5 - Hearing	
Present the case to the Hearing panel detailing allegations/concerns and outcome of investigation report.	
Call any witnesses	
Step 6 – Lifting Exclusion or Restrictions following the hearing	
If the doctor has been excluded or had restrictions on duties placed upon them, meet to discuss their return to work/duties. (Discuss any necessary updating/training as well as emotional support).	
KEY NOTE: At any point in the process where the Case Manager has reached the clear judgement that a doctor is considered to be a serious potential danger to patients or staff, that doctor must be referred to the regulatory body, whether or not the case has been referred to the NCAS, consideration must be given to whether the issue of an alert letter should be requested.	

Role of Case Investigator:

Step 1 – Immediate Action	
Arrange meeting with Case Manager to discuss the case.	
The Case Manager will provide clear terms of reference for the case. You must ensure that this is fully understood.	
Be mindful of potential breaches of confidentiality and that safeguards are in place throughout the investigation.	
Step 2 – Investigation	
Meet with relevant witnesses/individuals in relation to case (inform them that all statements and notes of interviews will be provided to doctor).	
If questions of clinical judgement are needed, liaise with the Clinical Adviser. If none has been appointed contact the Case Manager.	
Ensure sufficient written statements collected All statements to be in the witnesses own words, and reasonable steps taken to ensure they are signed and dated or approved in some other manner (for example an e-mail confirming the contents are true).	
Interview the doctor (who may be accompanied by the Doctors Companion) and take reasonable steps to ensure the statement is signed and dated or approved in some other manner and any witnesses reasonably identified by the doctor.	
Consider the need to interview further witnesses or re interview existing witnesses and take reasonable steps to ensure that any statement(s) are signed and dated or approved in some other manner	
In cases of formal exclusion, a preliminary report will be required asap by the Case Manager to enable them to decide on the next steps taken.	
Assist the Designated Board Member in reviewing the progress of the case should they make contact.	
Where further concerns are identified during the investigation the Case Investigator must speak to the Case Manager so a decision can be taken as to whether the terms of reference should be expanded or amended.	
Step 3 – Drafting the Investigation Report	
Use the investigation report template. Pass the final report to Case Manager within 5 working days of investigation being completed.	
The report should give sufficient information in order for Case Manager to make a decision (see 6.6 for details).	
Key Timescales:	
Investigation to be completed within 8 weeks of appointment	
In exceptional circumstances an extension may be required and this is agreed by the Case Manager and doctor informed of extension in writing.	

Role of Determining Manager (for conduct related issues):

Step 1 – The Hearing	
Confirm the reasons for the hearing and outline the procedure for the meeting making sure that the doctor is aware of their right to be accompanied.	
If matters are raised during the hearing that you need to consider further or require further investigation, you should adjourn the hearing to allow this to happen. When hearing resumes the doctor must have an opportunity to hear and respond to any new information	
Adjournments can be requested by either side during the hearing.	
The hearing will also consider any grievances/concerns raised in relation to the process undertaken if they are not resolved at an earlier stage in the process by the Case Investigator or Case Manager.	
Step 2 – Failure of the Doctor to Attend Hearing	
If the doctor fails to attend, reasonable steps should be taken to establish the reason and, in the absence of any justifiable reason, the hearing will go ahead in their absence.	
Where, however, there is a justifiable reason or the doctor or their representative cannot be contacted, reasonable steps should be taken to advise them of an alternative date for the hearing. Advise them that a further failure to attend will result in a decision being made in their absence.	
Step 3 – The Decision of the Hearing	
Determine whether on the balance of probabilities any of the allegations are proven (it should be noted that the burden of proof in disciplinary cases is "on the balance of probability").	
Determine whether the individual is performing at a satisfactory level on the balance of probabilities and if not does the doctor realise and accept that there is a problem with their work performance.	
Before deciding what form of disciplinary action should be taken, if any, the Determining Manager should consider: • The doctor's "live" disciplinary record and whether they have been made fully aware of the standards required; and • Any mitigating circumstances which make it appropriate to lessen the severity of the action; and • The action taken in similar cases in the past (HR or Medical Staffing will be able to assist), and • Whether the proposed action is reasonable in the circumstances • If a decision can be reached the same day the doctor or their representative may be advised verbally of the outcome of the disciplinary hearing • Alternatively write to the doctor within 5 days, confirming the decision taken Full details of the range of Disciplinary Sanctions and details of what needs to be included in outcome letters can be found at Appendix 4.	

Role of Designated Board Member and Chief Executive

Role of Designated Board Member	
Step 1 - Appointment	
The Chair will be approached by Medical Development and briefed about the case.	
The Chair will approach a non-executive board member and they will be appointed to oversee the case and ensure momentum is maintained.	
Medical Development will be informed of the name of the board member.	
Should Exclusion Occur:	
A detailed report is provided when requested to the Designated Board Member and they will be responsible for monitoring the situation until the Exclusion has been lifted.	
The Designated Board Member must ensure that the time frames for investigation or Exclusion are consistent with the principles of article 6 of the European convention on human rights.	
The Designated Board Member is also responsible for considering any representations from the doctor as regards exclusion or the conduct of the investigation	
The Designated Board Member has a responsibility for ensuring that these procedures 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.	
Board members may be required to sit as members of a disciplinary or appeal panel. Therefore, information given to the board will only be sufficient to enable them to satisfy themselves that the procedures are being followed. Only the Designated Board Member will be involved to any significant degree in each review.	

Role of Chief Executive:	
Once a serious concern is raised about a doctor this will be registered with the Chief Executive.	
When an Exclusion decision has been extended three times, the Chief Executive will ensure NCAS have been approached for advice and explain to the Designated Board Member why an extension should be granted will inform the relevant Health Education Board of what action is proposed to resolve the situation.	
Key Timescales:	
Initial Exclusion – 2 weeks	
Exclusion must not be for more than 4 weeks at a time	
Reviews must take place before the end of each 4 week period	
A summary of progress of each case is required at the end of each period of Exclusion.	

Appendix 2 - Common types of remediation

Drafting the plan

- SMART objectives
- Interventions
- Timescales
- Setting milestones/progress points
- Roles and responsibilities
- Specifying evidence.
- Negotiating the plan
- Monitoring of progress
- Decision making

Supervision

- supervised practice
- formative work based assessments, case-based reviews, mini-clinical evaluation exercises (Mini-CEX), objective structured, clinical examinations (OSCE), on-site assessment and training (OSAT), video recording, simulation, patient and colleague feedback

Development

- Educational activities

  Re-training and re-skilling activities including tutorials, workshops, courses, e-learning, focused reading, language/communication skills-based activities
- Specialist interventions

  Behavioural coaching, occupational, psychological and specialist health (mental health and addiction) interventions, counselling (career or therapeutic), boundary awareness, cultural competence
- Doctor support

  Mentoring, vocational rehabilitation, protected learning and development time, career guidance, financial advice
- Organisational support

  Human resource, legal advice, team or workplace mediation

Scope of work

- amendment/restriction of aspects of scope of work

The hallmarks of an appropriate, effective intervention

- Tailored to the problem
- Suits the individual's learning style
- Results in genuine, long lasting change
- Requires an acceptable investment of time, money, energy or other resources
- Makes a quantifiable difference
- Clarity and client engagement are essential
- Personality, motivation and organisational factors all impact on individual performance

(Source: RST Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a doctor's practice v1 March 2012)

Appendix 3 - Examples of misconduct / gross misconduct

In the interest of good employee relations, this summary seeks to inform employees how particular issues are viewed by the Trust to ensure that employees and managers understand how issues may be addressed.

This document describes examples of misconduct which the Trust considers to be sufficiently serious as to warrant disciplinary action. It must be noted that the following lists are **purely illustrative and not exhaustive** since employment will also be governed by local workplace rules, practices and procedures. The publication of these rules will not restrict the right of the Trust or any of its managers to determine what stage of the disciplinary procedure is appropriate in the light of the circumstances of each individual case, including summary dismissal.

For the sake of brevity, every type of misconduct referred to below is not necessarily repeated in every section. A particular type of misconduct may be treated as misconduct or gross misconduct depending on the facts of the case, and any impact upon patients will be taken into account.

Part 1 – Misconduct

Breaches of the following rules usually warrant the issue of a written warning, final written warning or dismissal with notice, depending upon the circumstances (Dismissal with notice for misconduct will normally be as a result of repeated warnings):

a) unacceptable behaviour/conduct towards patients
b) unauthorised absence
c) abuse or misuse of sickness pay/leave provisions
d) abuse or misuse of study leave provisions
e) breach of contract/terms and conditions of employment
f) participating without authority in other employment, trade, business or profession which is prejudicial to, or which adversely affects, employment with the Trust
g) private trading on Trust premises without permission(by Management) – whether or not for personal profit
h) failure to carry out reasonable instructions given by management effectively and in a timely manner
i) failure to report incidents in line with the policies and procedures of the Trust
j) unacceptable conduct contrary to any NHS policies, guidelines and standards as amended from time to time
k) any harassment or bullying of staff.
l) any conduct or performance bringing the NHS/the Trust into public disrepute (including inappropriate use of social media)
m) any breach of the Trust's standing orders and financial standing instructions
n) breach of the Trust's IT security policies
o) any breach of directorate, department or human resource policy rules or procedures
p) failure to adequately perform duties of individual job descriptions
q) misuse or abuse of facilities or time off provisions granted to Trade Unions and Professional Organisations
r) breach of the Health and Safety rules and/or statutory regulations regarding Health and Safety
s) failure to ensure the safe keeping of personal identifiable information or commercially sensitive information.
t) failure to protect and ensure the safekeeping of Trust property including lease cars.
u) carelessness or negligence in the performance of duties.

v) Breaches of the Trust Values and Behaviours

Part 2 – Gross Misconduct

The following are examples of gross misconduct that may warrant summary dismissal (dismissal without notice), even for a first offence:

a) dishonesty relating to employment matters (e.g. fraudulent use of flexi time system, fraudulent travel/subsistence claims, dishonestly obtaining permission for authorised absence, collusion in attempting to take unauthorised absence)
b) gross fundamental breach of contract/terms and conditions of employment (including the Trust Values and Behaviours)
c) theft of any NHS or Trust property, or theft of any other property belonging to another whilst on duty or the removal of NHS or Trust property from the premises without authorisation to do so
d) malicious or reckless damage to NHS property or the property of others whilst on duty
e) fraud – any deliberate falsification of records or any attempts to defraud the Trust or any patient, member of staff or member of the public
f) assault, intimidation, threatening behaviour, physical abuse or verbal abuse upon a patient, member of staff or member of the public
g) professional misconduct
h) the receiving or offering of bribes
i) committing a criminal offence whilst on duty or whilst acting on behalf of the Trust or off duty if it is of a nature that the Trust loses confidence in the employee.
j) failing to inform the Trust of any arrest or charge in connection with any criminal offence or served with a summons on criminal charges (excluding parking offences or minor motoring offences)
k) illegal possession, use, or distribution of drugs
l) incapacity to perform duties due to the influence of alcohol, solvents or drug abuse
m) any serious carelessness or negligence in the performance of duties including that which threatens the health and safety of patients, visitors, or staff, including a failure to or an unreasonable delay to report a serious incident
n) any harassment or victimising a Whistle Blower, or deliberate attempts to cover up concerns
o) breach of confidentiality – disclosure of privileged and confidential information to unauthorised persons or organisations.
p) serious misrepresentation, or providing false or misleading information in any application for employment or deliberately withholding personal information, including qualifications held and legal charges or offences not covered by exemption under the Rehabilitation of Offenders Act, at the time of appointment or at any time during employment
q) seeking and receiving gifts/gratuities for services rendered in the course of employment or otherwise (see Standards of Business Conduct)
r) intentional or serious breach of the Trust's Equality and Diversity Policy.
s) serious breach of health and safety rules and/or statutory regulations regarding health and safety
t) ill treatment, abuse, or mishandling of patients
u) gross insubordination
v) withdrawal of statutory qualifications required for the post or failure to register/reregister.
w) misuse, carelessness or negligence in the use of an occupational Smart Card
x) serious breach of the Trust's policy regarding the safety of person identifiable information.
y) vexatious or malicious complaints not made in good faith
z) accessing with intent or forwarding pornography using the Trust's systems

Appendix 4 - Determining appropriate disciplinary sanction

In determining the appropriate disciplinary sanction, the nature and seriousness of the offence needs to be considered. In the case of minor offences and poor performance, disciplinary sanctions will normally be progressive.

For all disciplinary sanctions short of dismissal or an alternative to dismissal there will be a specified period of time during which any further misconduct/failure to improve performance to a satisfactory level of any type will normally lead to further disciplinary action being taken, usually at the next level. The various levels and periods of time are indicated below:

Oral Warning

Oral agreement that there must be an improvement within a specified time scale with a written statement of what is required and if appropriate how it might be achieved.

Written Warning

Depending on the circumstances of each particular case the warning may be operational for a period of **between 6 and 18 months**, after which time the warning will be considered to be spent. A written warning may be issued in the case of:

- misconduct,
- where there is a recurrence of misconduct and the doctor has previously been counselled as part of the informal process or,
- where an doctor's performance does not improve within the review period following informal processes aimed at improving performance.

Final Written Warning

The warning will be operational for a period of between 12 and 24 months. A final written warning may be given if there is:

- a recurrence of misconduct within the period of another warning,
- an doctor's performance does not improve within the review period or lapses again during the period of a written warning.
- Misconduct / poor performance of such a serious nature that only one warning should be given

Dismissal

Dismissal is the ultimate step that can be taken by the Trust in the disciplinary process. Doctors will not normally be dismissed without a previous warning except in the case of gross misconduct. The Trust has the right to pay in lieu of notice.

Summary Dismissal

Summary dismissal is the termination of an individual's employment with the Trust without notice and should only be used in cases of gross misconduct

Dismissal is appropriate when:

- Circumstances have resulted in written warning(s) being issued in accordance with the Trust procedure and the doctor's response is regarded as inappropriate, inadequate or insufficient.
- Particular circumstances are such that the Determining Manager/Panel considers that the doctor should not continue in employment as the offence constitutes gross misconduct.

Alternatives to Dismissal accompanied by a Final Written Warning

An alternative to dismissal will be considered in all cases where the disciplinary outcome is that dismissal should take place but there are mitigating circumstances to take into account.

The Determining Manager/Panel may decide to offer to transfer the individual to a vacant post elsewhere in the Trust. This will be accompanied with a final written warning.

If an alternative to dismissal is refused this should be recorded and the doctor will be dismissed.

Reporting to Professional Bodies

Depending upon the seriousness of the offence, the Trust may be obliged to inform the professional body at any stage of the formal procedure.

Where a Determining Manager/Panel finds it necessary to recommend referral to a professional body the doctor must be notified in writing of the intention to do so.

Reporting to other Agencies

The Trust will also involve the Safeguarding Children or Safeguarding Vulnerable Adults Procedures where appropriate. This should be done as soon as the allegations are first received. This could include:

- The Trust will make appropriate referrals to the Independent Safeguarding Authority
- The Trust will report matters involving suspected criminal / illegal activity to the police and/or NHS counter fraud.
- Where appropriate the Trust will request the NHS North of England to issue an Alert letter

Appendix 5 - Action planning framework

This template provides a way for a doctor and the Trust to consider systematically how an action plan might be constructed. The document should be confidential.

You can consider this as an agenda and stretch the boxes to the size you need, perhaps using landscape. Then pencil in possibilities and options and use meeting notes to record the decisions taken. Or you might use it to prepare for a meeting, asking different parties to think about a framework and then putting all the ideas on a table for discussion and producing a collective view of how a further training programme might be put together. Use the headings as they stand or reword.

Further guidance on this and other support material can be found on the NCAS website, section 3.2 of the Back on Track Framework for Further Training for more about what a framework should cover. If, after using the template, there is agreement in principle that a further training programme is the way forward, then you will be able to use the doctor action plan and Trust templates.

<table>
<tr><td>Likely timescale for completion</td><td colspan="3"></td></tr>
<tr><td>The role to which Dr X could return if concerns are addressed</td><td colspan="3"></td></tr>
<tr><td>Options to be considered if concerns are not addressed</td><td colspan="3"></td></tr>
<tr><td>Support to be offered to the Doctor during further training</td><td colspan="3"></td></tr>
<tr><td>Areas of concern</td><td>Suggested interventions which may contribute to development</td><td>Sources of evidence/supporting information which would inform decision-making</td><td>Resources</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Notes on areas of agreement or areas for further discussion</td><td colspan="3"></td></tr>
</table>

Appendix 6 - Template for investigation report

INVESTIGATION IN RELATION TO MEMBER OF STAFF

INVESTIGATION REPORT

Date of investigation report

Name of investigating officer
Investigating Officer

CONTENTS

SECTION 1 - TERMS OF REFERENCE *(including allegations and terms of reference pro forma and any amendments made by the Case Manager)*

SECTION 2 – BACKGROUND

2.1 Background Information

- Events surrounding the allegation(s)
- Evidence reviewed *(personal file, interviews, statements, datix forms, CCTV etc)*

SECTION 3 - TIMELINE

SECTION 4– FINDINGS *(referencing appendices where necessary)*

3.1 Allegation and finding

3.2 Allegation and finding etc

SECTION 5 – ADDITIONAL RELEVANT FINDINGS

(Eg review any disc sanctions on file, management issues, any mitigation discovered throughout the investigation.)

SECTION 6 – CONCLUSIONS

Summary of the findings

LIST OF APPENDICES *(any policies referred to must be included, statements, interview notes, datix forms etc)*

SECTION 1 – TERMS OF REFERENCE

1.1 Terms of reference *(including allegations and terms of reference pro forma* *and any amendments made by the Case Manager)*

SECTION 2 – BACKGROUND

2.1 Events Surrounding the Allegations

Summary of what was happening at time

2.2 Evidence reviewed

Staff Interviewed

List names of all staff interviewed and dates of interviews

Name	Role (at time of events)	Date Interviewed

Other Evidence Reviewed

Bullet point list of all other documents you may have reviewed, including floor plans, written statements, personal files, policies etc

SECTION 3 - FINDINGS

3.1 Allegation:

- **Insert wording of allegation**

3.2 Findings in relation to the above allegation:

The section should provide a bullet pointed summary of the key findings of the investigation, and how findings relate to each other. This should **not** simply be quotes from the investigation interviews.

E.g. There is general agreement that X was said, however person Y also recalls ….
There is clear contradiction between the people interviewed about the events that occurred.
Person X clearly believes Y, but person Z and A disagree with this position

All findings included in this section should be referenced to the evidence the findings were drawn from in the appendices

Summarise of the main points of the findings.

- Remember that you are not making a decision on whether or not something is or isn't upheld, you are just presenting the facts as you have gathered them and what they tell you

SECTION 4 SUMMARY OF ADDITIONAL FINDINGS

4.1 Summary of additional finding *(If there are any)*

SECTION 5 - TIMELINE

Date	Event
	Include: • Dates of interviews • Dates important letters were sent • Dates of meeting • Date investigation started • Date investigation report completed • Dates of any occ health referrals/appointments etc • Dates of any other important contact • Account for any delays throughout the investigation • Include meetings held by commissioning manager to update doctor

LIST OF APPENDICES

1
2
3
4
5
6
7
8

Appendix 7 - The role of NCAS

NCAS helps improve patient safety by helping to resolve concerns about the professional practice of doctors, dentists and pharmacists in the UK and overseas. They provide expert advice and support, clinical assessment and training to the NHS and other healthcare partners. They can be contacted at different stages of this process to offer specialist help and advice and the Case Manager, in conjunction with medical development, will ensure they are contacted accordingly.

NCAS state that 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 NCAS's processes are aimed at addressing all of these, particularly where local action has not been able to take matters forward successfully. The NCAS's methods of working therefore assume commitment by all parties to take part constructively in a referral to the NCAS. For example, its assessors work to formal terms of reference, decided on after input from the doctor and the referring body.

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

- Performance falling well short of what doctors could be expected to do in similar circumstances Alternatively or additionally, problems that are ongoing.
- 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. NCAS may advise on this.
- Where the Trust is considering excluding a doctor it is important for the NCAS to know of this at an early stage, so that alternatives to Exclusion are considered.
- A doctor undergoing assessment by the NCAS must if asked give an undertaking not to practise in the NHS or private sector other than their main place of NHS employment until the NCAS assessment is complete

Failure to co-operate with a referral to NCAS may be seen as evidence of a lack of willingness on the part of the doctor to work with the Trust on resolving performance difficulties.

If the doctor chooses not to co-operate with such a referral, that may limit the options open to the Trust and may necessitate disciplinary action and consideration of referral to the GMC.

Appendix 8 - Supporting doctors during an investigation

Background

Being involved at any stage of the medical remediation and disciplinary procedure can be a stressful time and as such the Trust wants to ensure it provides as much support as possible during this difficult period. When concerns are raised, it is often necessary to gather the facts around the issues so that the Trust can make reasonable decisions as to what actions to take.

On occasions this may lead to proceeding through the formal part of the procedure and it is acknowledged that this can be a particularly isolating period and the Trust, in partnership with the LNC, has taken the following measures to support colleagues.

Providing support

The Trust has a number of consultant colleagues that are able to provide support and guidance and whom have volunteered to undertake this additional role having been already trained as mentors. From this pool, a colleague will be identified that is not in the same specialty or locality as yourself and has no knowledge of the case.

All those in the pool have received additional face to face training and will not be part of the medical management structure. This support mechanism is an entirely voluntary arrangement and there is no need for you to make contact with the person identified if you feel that it will not help you or you feel that it is not required.

What will be their role?

Their role will be to act as a 'friend' during this time, to listen to you and to offer sources of help/guidance for you to consider. They will not report back to Trust management about whether there has been contact made or about any conversations that you have held as these will be confidential, unless there is a duty of care to inform the Trust, as outlined by duties of a doctor in GMC guidance.

Signposting

As a result of the conversations, the colleague will be able to help signpost you to provide advice/guidance on such matters as:

1. ***Support channels***
    - Trust confidential advisor service
    - BMA Doctors well-being support service
    - Support from Occupational Health
    - Support from GP
    - Royal College Psychiatrists support service on coping with complaints

2. ***The medical remediation & disciplinary procedure***
    - Understanding of the process

3. ***Communication (if exclusion applies)***
    - Ensuring you receive core brief / weekly Trust bulletin
    - Service updates/Governance updates/Trust-wide medical staffing meeting
    - Access to CPD opportunities / M&S training

In addition to these core areas it is possible, if both parties agree, for the colleague to provide an independent sounding board to help clarify/rationalise their own views.