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INVESTIGATING PERFORMANCE CONCERNS

Primary Medical Services

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Identifying the need for and purpose of an investigation

Identifying the need for an investigation

1. Situations which might prompt a contracting organisation[1] to consider an investigation of an employee or contractor might include:

   - Concerns expressed by other Health and Social Care professionals, health care managers, students and non-clinical staff
   - Review of performance against job plans, annual appraisal, revalidation
   - Monitoring of data on performance and quality of care
   - Clinical governance, clinical audit and other quality improvement activities
   - Complaints about care or treatment raised by patients or relatives of patients (service users)
   - Information from a regulatory body
   - Litigation following allegations of negligence (it is recognised that these may not be declarable under the current performers list arrangements)
   - Information from the police or Coroner
   - Court judgements
   - Serious adverse incidents.

2. An investigation might be complex, time consuming and potentially costly. It may have unintended consequences both for those subject to the investigation and for the organisation conducting it. Before deciding on a formal investigation, the contracting organisation should undertake a preliminary investigation, taking account of the evidence to hand, whether a more detailed investigation would be likely to obtain further relevant evidence and any comments the practitioner wishes to make at that stage.

3. The preliminary investigation should be appropriately documented and recorded and should include:

   - Review of any relevant clinical or administrative records

   - Review of any report or documentation relating to the issues in question (e.g. serious adverse incident report, any letters relating to the issues or notes/statements made by individuals with knowledge of the issues). Formal witness statements may not have been drafted at this stage, but the individuals concerned should always make a written record as soon as they can while matters are still fresh in their minds

   - Interviewing of individuals may be appropriate as part of the preliminary investigation where clarification of the substance of the individuals' comments or the extent of his/her involvement is necessary

   - The preliminary investigation should be completed as quickly as possible, normally within, at most, a few days of issues being raised. The subject should always be given the opportunity to comment on the issues as they appear at the end of the investigation and any comments must be taken into account before any decision is taken as to whether any action (i.e. informal/formal action or a full investigation) is appropriate.

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[1] This term is used to include the current Health and Social Services Boards, The Health and Social Care Board post April 2009, Out of Hours Providers and any other organisation that may contract with doctors to provide General Medical Services.

4. Informal action which still needs to be appropriately documented and recorded for less serious concerns may be a more satisfactory method of resolving problems than a more formal route. Such informal action might include mediation or update training. Therefore, before committing to undertaking a detailed investigation you should consider:

- Have all immediately necessary steps been taken to protect patients and the wider public by responding promptly and effectively to the concerns that have been raised? Such steps need to be proportionate to the risk assessed, with total exclusion from the workplace an exceedingly rare, but sometimes necessary, action.

- Have all immediately necessary steps been taken to protect staff, including whistleblowers, to support the subject of the proposed investigation and protect any sources of evidence?

- Who should be made aware of the investigation?

  - The subject - The subject needs to know about the investigation and be given the opportunity to comment before any decision, including a decision to hold a disciplinary hearing is reached

  - The complainant – where a decision is made to embark upon a disciplinary investigation, action under the complaints procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the complaints procedure. The complainant must be advised in writing that a disciplinary investigation is under way, that they may be asked to take part in that process and that any aspect of the complaint not covered by the referral will be investigated under the HSC complaints procedure. The complaints process will impose its own timescales and conditions but, in general, people need to know that their concerns have been taken seriously and that appropriate action has been taken at the conclusion of the investigation. Arrangements for communicating patient safety incident with patients and their carers should be in line with that set out in *Safety First: A framework for Sustainable Improvement in the HPSS*.

  - The patient, if they (or their nominated advocate) are not the complainant

  - The Chief Executive and/or the Board of the organisation – organisations should have local policies in place governing how incidents are reported but remember that appeals arising from disciplinary processes may require the participation of Board members who have not been involved in the initial stages.

  - As far as is possible the practitioner's confidentiality should be respected by limiting information to those who justifiably need to know about the case.

- Does the organisation have clear and simply-written guidance that explains the process it is about to embark on and its links to disciplinary procedures?

- How much investigation is necessary? An investigation is unlikely to be necessary if the facts of the case have been agreed.

- The possibility of systems rather than personal failure should also be examined.

- Whether formally or informally dealt with, all concerns need to be investigated. Each case is different and needs to be dealt with according to the case circumstances. A clear audit trail including an appropriate risk assessment helps clarify if needed later why a particular matter was dealt with in a particular way at the time.

• Where the practitioner is the subject of an ongoing investigation by the Police, Counter Fraud Unit or a regulatory or licensing body then this does not necessarily prevent a local investigation into unrelated matters taking place but it would be advisable to consult the relevant organisation before commencing any local investigations. Where a local investigation is already underway and the contracting organisation becomes aware of another investigation then again liaison with the relevant body should take place.

Purpose of an investigation

5. Determining the purpose of the investigation you are planning will help you take the proper investigative measures. The purpose is summarised as the *terms of reference* and in turn these are based on the allegation that a rule or regulation has been breached. The evidence you are seeking will be directed at informing the decision that upholds or refutes that allegation.

6. You should ensure that all the relevant issues are encompassed in the terms of reference from the outset. The investigation will lose focus by inquiring into interesting but irrelevant issues that are outside of the terms of reference. If an issue arises that does not fit within the terms of reference, you should either seek approval to change them from the case manager or omit the issue from your investigation.

7. In all cases you should proceed as quickly as possible and explain any delays. Delay will lead to evidence becoming stale and the subject may argue that this prejudices his case. In planning the investigation, an indication of the likely resource required in terms of time and expertise, is useful. This will assist the investigator, and senior management, in identifying personnel and prioritising activity to ensure satisfactory progress. Of necessity, any initial assessment will require revision as the investigation develops.

Roles and responsibilities and selecting investigators

Roles and responsibilities

8. If the contracting organisation is faced with contested allegations about the conduct or capability of a practitioner and then decides to proceed down a formal route it should commission a formal investigation.

9. The contracting organisation should commission a formal investigation involving its own staff or calling on resources and expertise from another appropriate Health and Social Care organisation.

10. The practitioner concerned must be informed in writing by the contracting organisation as soon as it has been decided that an investigation is to be undertaken. The practitioner should be told the name of the case manager and the lead investigator and made aware of the specific allegations or concerns that have been raised as well as the terms of reference for the investigation.

11. Once an investigation starts the investigator will explain its likely course and timescale to the practitioner, unless, exceptionally, a decision is taken with the case manager that informing the practitioner could prejudice the investigation's outcome.

12. Generally, the practitioner must also be given the opportunity to see any correspondence relating to the case together with a list of the people that the investigator will interview.

13. The practitioner must also be afforded the opportunity to put their view of events to the investigator and given the opportunity to be accompanied. It is good practice for the investigator to interview the practitioner very early in the investigatory process.

14. The practitioner should be advised, in his own interest, not to discuss the case with witnesses as the appearance of influencing evidence may prejudice his position and raise serious probity issues.

15. During the investigation, the practitioner may be accompanied in any interview or hearing by a companion. In addition to a contracting organisation employed practitioner's statutory rights under the Employment Act 1999, the companion may be another employee of the HSC body; an official or lay representative of the British Medical Association or defence organisation; or a friend, partner or spouse. The companion may be legally qualified but he or she will not be acting in a legal capacity, which is to say that the practitioner may be accompanied by a lawyer as an adviser, but that the practitioner should speak for him/herself (where he/she is able to), the lawyer should not respond on behalf of the practitioner.

Selecting investigators

16. In all cases the investigation should be undertaken by appropriately experienced and trained investigators. The investigator must not have, and must not be perceived to have, any conflict of interest in relation to the complaint, or to the persons, the conduct or the policies and procedures that are the subject of investigation.

17. There will be no confidence in the outcome of an investigation where the process is tainted by actual or perceived conflict of interest. Any arguments made by the person who is the subject of the investigation about the integrity of the process can never be satisfactorily or totally rebutted. [If there has been a previous formal hearing involving the practitioner, so far as possible, members of any disciplinary panel should not be those who were previously involved].

18. Several clinical managers should be appropriately trained, to enable them to carry out this role when required.

19. Investigations should be managed by a lead investigator who is identified to the practitioner and is available to answer any questions that might arise about the investigation's progress. The contracting organisation should always consider, where possible, sharing this information with the complainant.

20. For investigations of clinical capability, the investigator should also be a practitioner. For investigations concerning professional or personal conduct, the investigator may be nominated by the HR adviser to the contracting organisation.

21. The lead investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings to the case manager and the contracting organisation. The investigator does not make the decision on what action should be taken nor whether the employee should be excluded from work.

Collecting and documenting evidence

Collecting evidence

22. The investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter. The investigator should therefore take account of positive indicators as well as any negative indicators and any relevant national or local benchmarks.

23. It is important that the investigation collects all the evidence that may be available relating to the concerns or allegations being made. This will involve interviewing all those who may be able to provide information and making a careful note of their evidence. Where possible and depending on the circumstances, this will include patients, their relatives and the practitioner concerned.

24. If any case is to proceed, evidence has to be demonstrated, whether to the contracting organisation Board, the Tribunal, the GMC or in the courts. But how do you assess evidence and decide what weight a tribunal is likely to give to each piece of evidence? In court the rules of evidence can become complicated but there are some simple questions that should always be asked:

- What is the evidence and is it written? Written evidence is not superior to oral evidence: it is simply more clearly defined and so less prone to (but not immune from – witnesses do alter statements) being changed. And evidence, even if written, needs careful consideration to be sure of exactly what is being said – and how firmly it is being said. Witness statements are best in the words of the witness, signed by the witness and dated.

- How recent is the evidence? The general rule is that the older the evidence the less the weight that should be given to it. So the fact that doctor X faced a similar allegation in 1997 to that facing him now is likely to carry a lot less weight than if a previous similar allegation was made only three months ago

- Is there a pattern to allegations against the practitioner? A pattern of unacceptable behaviour is likely to be more significant evidence than an isolated incident. (But note that if similar allegations have not been dealt with in the past, it may give scope for the practitioner to argue unreasonableness and inconsistency on the part of the contracting organisation and thus offer some defence against the current allegations)

- How direct is the evidence? Factual evidence is likely to carry more weight than opinions from witnesses and unsupported anecdotal evidence is unlikely to be worth much

- How credible and compelling is the evidence, how cogent is the evidence and how likely is the evidence to be impugned?

Access to GP medical records

25. A lack of understanding of the law and the regulations governing the confidentiality of medical records has caused delay in some investigations.

26. General provisions relating to record keeping are contained in the Freedom of Information Act and Data Protection Act. The Data Protection Act 1998 governs access to the health records of living people. But generally, where, the Health and Social Care body can demonstrate a public interest case to access individual medical records without the knowledge and/or consent of the patient and/or the practitioner, it is unlikely to be criticised by the courts.

27. Part 5 of the Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004 set out the requirements for the keeping of medical records.

28. These requirements are in turn reflected in Part 15 of the standard GMS contract which requires the contractor to keep either computer records or, if they are written records, to record them on forms supplied by the Board, and to include in the records clinical reports sent by any other health professionals who have treated the patient.

GP medical records of living patients

29. Under common law, staff are permitted to disclose confidential information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others.

30. Contractors are required, at the request of the Board, to provide or allow access to ‘any information’ which is reasonably required in connection with the Board’s functions. The Department’s guidance accompanying the Confidentiality and Disclosure of Information Directions refers at section 30 to the circumstances in which the Board may need to access and obtain information that identifies individual patients.

GP medical records of deceased patients

31. Health records relating to deceased people do not carry a common law duty of confidentiality. However, it is Department of Health and General Medical Council policy that records relating to deceased people should be treated with the same level of confidentiality as those relating to living people.

32. When a patient moves away or dies, the contractor must provide the Board with the complete records relating to the patient. If the records are computerised, the contractor must not disable, or attempt to disable, either the security measures or the audit and system management functions in the record. In practice, what is found in the record is often a summary print out of the electronic file. However, many practices retain deceased patients’ electronic records on their own computer systems.

33. When a patient dies, their GP health records are transferred to the Central Services Agency[2] (CSA). The Department recommends that GP records are kept for a minimum of 10 years (HSS/PCCD 1/2000) after a patient's death although many are held for longer. Once returned to the CSA, the CSA has the authority to determine access to the medical records of deceased patients.

Access to premises

34. Many GPs own, or part-own in partnership, their surgery premises. The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004 has provision for the Boards to enter and inspect the practice premises at any reasonable time.

35. If the practitioner were to seek to obstruct a Board in carrying out a legitimate function, this would raise contractual issues as well as, potentially, further issues relating to professional conduct.

Ensuring equality and fairness

36. Unfair discrimination occurs as a result of prejudice, misconception and stereotyping which hinders the proper consideration of an individual's skills, abilities, potential and experience. It can be direct or indirect, intentional or unintentional. However, contracting organisation staff will need to be aware of the commitment to equality and the positive recognition of diversity and have a clear understanding of how discrimination can occur. Contracting organisations will wish to take account of good practice in making available appropriate training in ensuring and valuing equality and diversity.

37. The principles of fairness and natural justice as well as any Human Rights Act considerations need to be taken into account (the NCAS toolkit contains some guidance on these points - http://www.ncas.npsa.nhs.uk/toolkit). Essentially, natural justice requires that the individual in question:

    - knows what is said against him/her

    - has his/her comments taken into account before any decision is made

    - and that those making the decision are not the same people as those making the criticisms.

38. Fairness, natural justice and human rights issues are important and if not handled properly, may derail the whole investigation and lead to a legal challenge.

39. The procedures set out in the Performers List Regulations (Statutory Rule 2004 No 149 as amended by SR 2008 No 434 which came into operation on 8/12/08) aim to ensure a fair hearing in cases where a practitioner's inclusion on the list is in question, including criteria for decisions on removal and contingent removal; oral hearings and the appeal process.

[2] Or the successor organisation post April 2009.

Interviewing skills

40. Interviewing methods and investigative techniques have been the subject of much research, particularly in connection with police inquiries and from an ethical standpoint. Police use a PEACE model to structure interviews, whether of victims, suspects or witnesses. The model is intended to reduce procedural wrangling. Capability interviews have the same need. PEACE stands for:

    - Preparation and planning
    - Engage and explain
    - Account
    - Closure
    - Evaluation.

41. It is best practice for a second note-taker to be present, whose identity should be made known to the interviewee beforehand, in case there are objections to the person chosen. The draft record of the interview should be shared with the interviewee as soon as practicable after the interview. The interviewee should be asked to comment within a reasonable timescale and any comments should be attached to record, which should be amended if considered appropriate. Tape recording might also be considered, though the risk is that it makes the process seem more legalistic.

42. If recording is used at all, then it should be with a two-headed police-type tape recorder which allows both parties to have a copy of the tape at the end of the interview. The tape can then be used to prepare an agreed and accurate note or transcript, after which it can be erased.

43. Interviewing skills are crucial to successful investigation. Poor interviewing influences responses, while good interviewing helps people to put their thoughts in order and express them. Interviewing skills should not be practised first on someone whose career is possibly on the line. For organisations without in-house training capacity, training organisations run courses on investigation skills training.

44. Interviewers should:

    - Assess whether the interviewee has any special requirements - particularly in terms of communications issues or cultural issues – that would assist a proper level of understanding between interviewer and interviewee.
    - Ensure that any identified special needs are met e.g. interpreters, hearing induction loop; specialist communication skills for interviewing a patient with a learning disability etc.
    - Explain what they will do with the information given – i.e. who else will know of it
    - Avoid leading questions but probe and follow up leads
    - Pay attention to body language and pick up signs of distress
    - Ask questions based on fact rather than anecdote

- Avoid referring back to earlier investigations which have been resolved or which are not relevant to the present investigation

- Ask open-ended questions to ascertain causes

- Use persuasion and communication rather than coercion or confrontation

- Allow silence but use reflective comments to encourage a discussion to resume

- Know how to intervene tactfully when the interviewee is going off target

- Avoid expressing opinions and ask questions from both sides of an issue

- Ask a question in the same way each time, where a question has to be asked of several people

- Signal the end of the interview but give the interviewee a chance to make any additional comments.

- Provide witnesses with a written transcript of the notes taken, together with their signature confirming that these are an accurate record of their interview. Alternatively a formal witness statement should be produced and signed and dated by them. The witness should be allowed to be accompanied if they request this but that person is only there to support them, not to speak on their behalf.

Documentation

45. Any local procedures that you may rely on should be clearly set out and documents circulated in advance of any local investigation being undertaken.

46. Comprehensive minutes should be prepared of meetings that relate to individual cases. Guidance on the requirements for public bodies to process, retain records and keep them secure in line with the Data Protection Act is available from the Information Commissioner's Office.

47. All participants should be told, in advance of any interview, how the meeting will be minuted or recorded.

Safeguarding information

48. The law requires confidentiality about concerns relating to the individual practitioner to be respected unless the duty of confidentiality to the individual is outweighed by the public interest for the information to be disclosed to another body. While in nearly all cases personal information should be kept confidential, the public interest argument should always be considered because failure to make an appropriate disclosure may have serious consequences, possibly for patients.

49. Where any disclosure is appropriate, disclosure should be kept to the necessary minimum and should virtually always be to specified individuals or bodies who are themselves under a duty of confidentiality about the information.

50. Witnesses and patients should be aware and provide consent if their information is to be shared with other parties.

51. When conducting a local investigation, it may sometimes be necessary for the Board to request confidential patient information from a practice. The Department's guidance on Confidentiality (The Protection and Use of Patient and Client information) describes the circumstances in which such information might be lawfully disclosed**.**

Whistle-blowing and anonymity

52. NHS Employers have published guidance on whistle-blowing for GPs [www.nhsemployers.org/excellence/whistleblowing.cfm].

53. The evidence of informants and witnesses is often crucial to the investigation, particularly in cases of misconduct. When a practitioner's conduct or clinical performance is under investigation, they must know the full extent of the concerns that are under investigation and have the opportunity to comment on, and question, any evidence that has been provided. The rare exception is where the concern is of a criminal or fraudulent nature and notification could prejudice the investigation.

54. However, colleagues and employees of the practitioner are often reluctant or unwilling to be identified in the course of an investigation and may seek to provide information anonymously. In such cases, the investigator needs to strike a balance between the rights of the practitioner under investigation and the need to collect the evidence.

55. There are circumstances where it may be possible to proceed even if the practitioner is not informed of the identity of witnesses. What is important is that the practitioner knows the case they have to answer. Each situation must be judged on its merits but consider:

   - Why does the informant want to remain anonymous? As long as the concerns are genuine, the informant should be protected by any local policy on whistle-blowing and by the provisions of the Public Interest Disclosure Act

   - A preference to avoid being seen as the cause of a problem is not a sufficient reason for preserving anonymity

   - Registered healthcare professionals are under an obligation to report issues that may be putting patients at risk

   - Cases where anonymity has been held to be reasonable by the courts include those involving sexual misconduct or those in which there is a real or perceived risk of harm to the informant. In these circumstances, the investigator should take a full statement from the witness. This full statement should then be reduced by erasing the parts from which the witness could be identified

   - If anonymous information is to be used to build a case, the investigator should record all the issues have been considered and the reasons for anonymity. The investigator should be available at any subsequent hearing to be cross examined on the anonymous evidence and the reasons for anonymity.

Timescales

56. ***Maintaining High Professional Standards in a Modern HPSS (MHPS)*** [www.dhsspsni.gov.uk/hrd_suspensions_framework.pdf] provides useful standards for the conduct of an investigation and the general guidance will be helpful whatever disciplinary regulations are followed. The principles set out in this can be applied to those cases which require investigation under the Performers List Regulations.

57. If during the course of the investigation it transpires that the case involves more complex clinical issues than first anticipated, the case manager should consider whether an independent practitioner from another HSC body should be invited to assist.

58. In accordance with MHPS requirements the lead investigator should complete the investigation within 4 weeks of appointment and submit their report to the case manager within a further 5 days. It would be good practice to try and meet this timescale target in all cases irrespective of whether MHPS applies.

Support for the practitioner and complainant

Supporting the practitioner

59. Until the investigation has been completed and the case against them has been proved, the practitioner must be assumed to be innocent of all charges. The investigation may reveal that concerns over conduct or performance are exclusively or predominantly due to an underlying health problem. Should this be the case, appropriate measures to deal with the underlying problem are necessary. The health problem may also give rise to issues of patient safety, necessitating appropriate action to address.

60. Steps should be taken to protect the practitioner's reputation while the facts are still under investigation. They should be offered psychological support and encouraged to remain in touch and up to date with their career. The local representative committee (e.g. local medical committee) needs to be involved and in touch at every stage.

61. The majority of investigations disclose either no problem or, at most, a problem that permits the practitioner to remain in post. The investigation should be conducted in a way that recognises that the contracting organisation may need to facilitate the possibility of the practitioner's return to unrestricted practice. As far as is practical the practitioner's confidentiality should be maintained by limiting information to those who justifiably need to know about the case.

Support for the complainant

62. Making a complaint or raising a concern may be a difficult decision for many people. As such, the local processes for making a complaint or for whistle-blowing should be well publicised and disseminated. This is not to encourage unfounded criticism being raised but to ensure that matters that should be reported are appropriately channelled and dealt with within the organisation by those who have the training and experience to act upon them and reassure those raising the concern that this is being addressed.

63. The HPSS Complaints Procedures[3] sets out the requirements of an effective complaints handling process. All HSC organisations must have a designated Complaints Manager who is readily accessible to both the public and staff. The Complaints Manager has a key role in ensuring that appropriate support is available including signposting to the support and advice services offered by the HSS Councils and independent advocacy services.

64. Whistleblowers should be supported in accordance with local polices. The organisation Public Concern at Work can also offer support to individuals via their helpline (helpline @pcaw.co.uk).

[3] *Complaints in Health & Social Care: Standards and Guidelines for Resolution and Learning* will come into effect on 1 April 2009