

General
Medical
Council

Executive Board meeting - 17 December 18

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Agenda item:	9
Report title:	Outcome of the Public Interest Concerns pilot
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Action:	To consider

Executive summary

This paper evaluates the public interest concerns (PIC) pilot. The pilot was started in July 2016 and its aim was to test changes to the way that employers and contractors of doctors make referrals into our fitness to practise procedures and the way that we provide safeguards for doctors that are whistleblowers.

The Executive Report (at Annex A) provides additional detail around the actions taken in the pilot and the outcomes of it. The Executive Report further provides a series of recommendations to improve the effectiveness of the current pilot process and identifies requirements for next steps for the PIC process.

Recommendations

The Executive Board is asked to:

- a** Note the contents of this report.
- b** To consider whether to approve the pilot model for roll out to business as usual with the improvements highlighted in the paper or whether to continue to pilot the model for longer and introduce the improvements within the pilot.

Outcome of the Public Interest Concerns provisional enquiry pilot

Background

- 1** In March 2015, we published an independent review that we had commissioned from Sir Anthony Hooper QC, about doctors who have raised concerns in the public interest. Sir Anthony made eight recommendations in his report most of which are designed to provide assurance that GMC procedures are not used to retaliate against a whistleblower. In response, in July 2015 the GMC published an action plan (see Annex B). As part of that plan, in July 2016, we started a pilot to test safeguards for doctors who are whistleblowers.

The pilot model

- 2** Anyone referring a doctor to the GMC is expected to complete a referral form which requires disclosure of any whistleblowing history and the completion of a statement by the referrer that the referral is made in good faith and is, to the best of their knowledge, accurate and fair.
- 3** Cases are assessed against pilot criteria and referred by an Assistant Registrar to a pilot review group where the Assistant Registrar discusses the case with the pilot co-ordinator and the available FTP Assistant Directors. They are further assessed by the group to ensure they meet the fitness to practise threshold and to ensure that there is a whistleblowing context. If so the group assesses whether there is evidence to support the allegations that is independent of any organisation or individual that may be involved in the whistleblowing history. If not, provisional enquiries are undertaken to seek to obtain such independent evidence without opening a formal investigation. This can involve obtaining information from independent third parties, medical records and/or an expert opinion.
- 4** Where a formal investigation is necessary, GMC Legal draft the investigation plan to focus on independent corroboration of the concerns. Any whistleblowing history is flagged for decision makers, who have been trained and are supported by guidance about how to weigh witness testimony in these cases.

Pilot volumes and outcomes

- 5** Since the pilot was introduced, all cases where the referrer has identified public interest concerns or has failed to complete the public interest concerns declaration have been assessed within the pilot and, following initial assessment, 43 cases have been referred to the pilot review group for consideration. Following more detailed consideration by the pilot group:

- a** 11 cases were closed because they did not meet our investigation threshold.

- b** 16 cases did not have a whistleblowing context.
 - c** 16 cases were initially considered suitable for inclusion in the pilot but 3 were subsequently removed from the pilot when provisional enquiries confirmed they did not have a whistleblowing context.
- 6** Further details of the cases are contained at Annex A.
- 7** The status of the remaining 13 pilot cases is as follows:
- a** Two have closed with no action, because provisional enquiries found that there was not sufficient evidence of allegations of impaired fitness to practise. In these cases, the ELAs provide feedback to the referrer about the referral.
 - b** Four are currently in the provisional enquiries process awaiting responses to enquiries.
 - c** Six are currently under S1 formal investigation with pilot safeguards.
 - d** One has concluded with undertakings following a S1 formal investigation with pilot safeguards.

Success of the pilot

- 8** The purpose of the pilot was to provide assurance that employers are not able to use the GMC to retaliate against whistleblowers. The introduction of the RO referral form requiring disclosure of any whistleblowing history and a declaration of good faith is likely to create a significant barrier to using the fitness to practise process in that way. The role of the Employer Liaison Advisers (ELAs) in promoting discussion of cases prior to referral to the GMC also provides an important safeguard.
- 9** This approach appears to have been successful because, even though the pilot model has a low threshold for including cases in the pilot, numbers of cases found to be eligible for inclusion in the pilot are relatively low.
- 10** The pilot also seeks to ensure that, if we receive a referral of a whistleblower into the GMC's fitness to practise process, we aim to identify if there is reliable evidence to support allegations of impaired fitness to practise, without subjecting the doctor to a formal investigation.
- 11** To date, only 2 pilot cases have concluded. Both of those are cases where, by undertaking provisional enquiries, we have ascertained that there is no reliable evidence to support allegations of impaired fitness to practise. However, by their nature, such conclude sooner than formal investigations so it is not clear at this stage

what percentage of pilot cases as a whole may be cases where we find that there is no reliable evidence to support allegations of impaired fitness to practise.

- 12** What we can say is that, for those 2 doctors, without the benefit of the pilot process, the experience of being formally investigated would have amounted to a detriment involving significantly more stress and delay.

Timeliness

- 13** The purpose of provisional enquiries in non-Hooper cases is to carry out swift enquiries in order to avoid an unnecessary full investigation and reduce delay.
- 14** For this pilot, the purpose of provisional enquiries is slightly different. These always relate to employer referrals rather than patient complaints and the purpose is to safeguard against an employer making a referral to retaliate against a doctor for raising whistleblowing concerns. As would be expected, these cases involve very difficult and complex histories, where it can be challenging to identify whether there are real concerns about the doctor or whether the doctor is being treated unfairly and we can encounter difficulties getting independent information. We try to progress these cases as swiftly as possible and we review them regularly and discuss them at the pilot review group, however our emphasis is on establishing whether the concerns have merit before opening a full investigation.
- 15** We have found therefore that cases referred into the pilot progress slowly and, as a result, can fail to achieve any of FTP's SLAs for case management. Detail about the time taken to deal with these types of cases and the steps we have taken to facilitate information sharing can be found at Annex A.
- 16** It is worth noting that, had we referred the provisional enquiries cases for a full investigation, as we would have in the past, these delays would also have been experienced in that process, increasing the detriment for the doctor.

Quality

- 17** While the volumes are low, we have taken a cautious approach to considering cases for the pilot, erring on the side of including cases where any doubt. Triage staff refer a steady flow of enquiries to the pilot review group for consideration and investigation staff have referred S1 cases where a whistleblowing context emerges during the course of an investigation. Pilot safeguards have been appropriately applied for both groups of cases.
- 18** The Executive Report at Annex A provides additional detail on the performance of the pilot.

Improvements identified

- 19** As outlined in Annex A, we have identified that the pilot model could be improved. The key improvements propose more guidance on:
- a** Cases where we receive a complaint about a medical manager in relation to their handling of whistleblowing both where there has been a previous referral of the complainant to fitness to practise and where there is, as yet, no referral of the complainant; and
 - b** Cases that are being monitored by the Case Review Team.

Next steps

- 20** We would have preferred to have more concluded cases in order to evaluate the pilot model but, after 28 months, we recognised the importance of analysing whether the model appears to be meeting the objective of providing assurance in relation to employers using the GMC to retaliate against whistleblowers.
- 21** To date, the model does appear to be meeting that objective on the basis that:
- a** With the use of the referral form and ELA intervention, the numbers of cases involving the referral of whistleblowers are low and,
 - b** The only 2 concluded cases so far demonstrate that the model enables us to close cases where there is no reliable evidence of allegations of impaired fitness to practise at triage, without opening a formal investigation - and to give feedback to the referrer.
- 22** If the Board prefers to continue to run the pilot for longer in order to have a greater volume of data, we can continue to do so. However, at current throughput it is worth pointing out that piloting for a further year may only provide evidence of a few more concluded cases. If the Board agrees to roll out to business as usual, we will focus on a small group of trained staff to run it rather than embedding it in the wider FTP process. These cases are low in volume and exceptionally complex.

General Medical Council

Annex A: Outcome of the Public Interest Concerns Pilot

Executive Board – November 2018

Working with doctors Working for patients

Contents

- Executive summary
- Success of the pilot
- Background – pilot process
- Learning from the pilot review group
- Recommendations

Glossary

AoI – Allegation of impairment

AR – Assistant Registrar

BAU – Business as usual

CARF – Case advice referral form

CE – Case Examiner

ELS - Employment Liaison Service

ELA - Employment Liaison Advisor

FtP – Fitness to Practise

GMC – General Medical Council

PE – Provisional enquiries

PID – Project initiation document

PIC – Public interest concern

RIT – Regional investigation team

RO – Responsible Officer

S1 – Stream 1 investigation

SLA – Service level agreement

SMT – Senior management team

Executive Summary

The pilot started in July 2016 and has allowed us to test our response to Sir Anthony Hooper's recommendations to change the way that employers refer into our fitness to practise procedures and the way that we provide safeguards for doctors who are whistleblowers.

Our pilot model involved:

- *A consistent process for employers and contractors to make referrals to the GMC that addresses any whistleblowing history*
 - Referral form asks whether the doctor being referred has raised public interest concerns and whether they were investigated.
 - Referrer asked to sign a declaration to confirm the referral has been made in good faith and is fair and accurate.
 - Follow up incomplete forms and if information is not forthcoming, assess the referral as if the doctor has raised patient safety or systems concerns.
- *Early identification of whistleblowers and seeking initial independent corroboration of the concerns before deciding whether a full investigation is required*
 - All referrals where the doctor has raised public interest concerns or the declaration is incomplete are referred to the pilot.
 - AR completes an initial assessment to determine whether the referral could meet the investigation threshold. If it does and the doctor is identified as a whistleblower the referral is reviewed by a pilot review group – comprising members of the senior management team and the AR.
 - The pilot review group assesses whether enquiries could be carried out in the PE process to independently corroborate the concerns in the referral.
- *Ensuring that, when a full investigation about a whistleblower is necessary, the investigation focuses on seeking independent corroboration of the concerns*
 - Legal provide input on the case plan on all S1 pilot cases to ensure it focuses on gathering evidence that will independently corroborate concerns raised.

- *Ensuring decision makers are aware of any history when making decisions and have appropriate training and guidance in making such decisions*
 - Paperwork provided to CEs at the end of the investigation highlights whistleblowing information.
 - Guidance produced for CEs and MPTS tribunals advising the issues to consider when weighing evidence in whistleblowing cases.
 - All decision makers have received whistleblowing training.

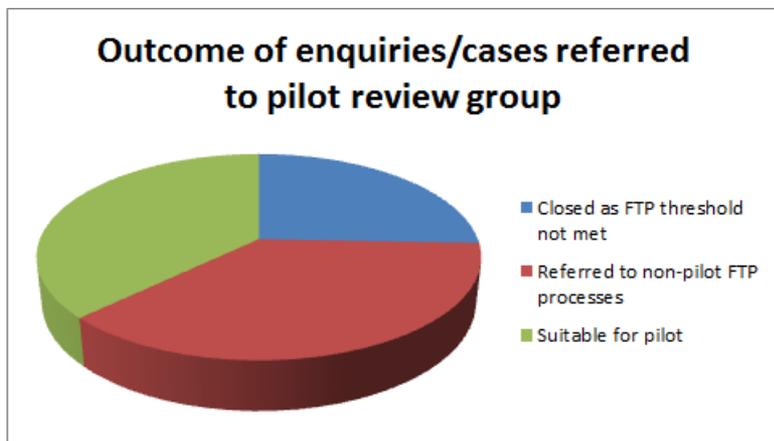
Work to address other recommendations:

- *Training our investigation teams*
 - Hill Dickinson delivered 'Whistleblowing: What it means for the GMC' over 21 face-to-face training sessions. Mandatory for FTP staff.
 - Compulsory e-learning module rolled out in May 2018 for new starters and refresher training in FTP. A similar module was rolled out to external customer facing staff in the Registration and Revalidation directorate.
- *Exploring an independent online system for recording concerns raised locally*
 - Hosted roundtable event in March 2016 to explore value and viability of this recommendation. Invited wide range of stakeholders including healthcare professionals and organisations that support whistleblowers. Consensus was that such a tool would distract from the emphasis on building openness in local cultures and, in light of that, we have not taken this recommendation forward.

Success of pilot (1)

Pilot volumes

- The pilot review group has considered 43 enquiries/cases referred by the AR – 16 were initially determined to be suitable for the pilot.



- While the volumes are low, there is a steady flow of enquiries referred to the pilot review group for consideration and furthermore cases in S1 are also referred when a PIC context emerges in the course of an investigation which would indicate that Investigations Officers are aware of a PIC context and the pilot.
- The operational guidance encourages staff to refer enquiries to the pilot review group if there is any uncertainty around the PIC context. This could be the reason why such a large proportion of those considered by the group are deemed not suitable for the pilot.

Pilot volumes/ Closure rate

Of the 16 enquiries/cases initially found suitable for the pilot:

- 11 were subjected to the pilot provisional enquiries process
- 3 were already in a S1 formal investigation when the whistleblowing context was identified (1 of these was already in S1 when the pilot started) and were subjected to S1 pilot safeguards.
- 2 were promoted directly to a S1 formal investigation and subject to pilot safeguards (as evidence of risks to the public were contained in the initial referral in one and the other related to a doctor that was already in S1 for related matters and the cases were joined).

Of the 11 cases that were subjected to pilot provisional enquiries:

- 3 were subsequently promoted to a S1 formal investigation under pilot safeguards when provisional enquiries identified evidence of risks to the public.
- 3 were subsequently removed from the pilot and promoted to a S1 formal investigation without pilot safeguards when provisional enquiries identified that there was no relevant whistleblowing context.

Removal of 3 cases from the pilot left a total of 13 cases in the pilot.

The status of those 13 pilot cases is as follows:

- 2 have closed with no action, as provisional enquiries found that there was not sufficient evidence of allegations of impaired fitness to practise. The ELAs are providing feedback to the referrer about the referral.
- 4 are currently in PEs awaiting responses to enquiries.
- 6 are currently in S1, being investigated with pilot safeguards.
- 1 has concluded with undertakings following a S1 formal investigation with pilot safeguards.

Success of pilot (2)

Timeliness

- Of the two enquiries that concluded in the PE process, due to lack of corroboration, one closed after 292 days and the other after 453 days. There are also 4 other enquiries ongoing in the PE process which were all received over 200 days ago. These enquiries are therefore in the provisional enquiry process for much longer than was intended for the usual PE process.
- All the PIC cases that are currently in S1 have missed their 6 month (and in most cases their 12 month) SLA.
- The time taken to look into these referrals is due to their complexity and because of the history between doctors and the referrer. We review them regularly and when we experience delays we deploy the ELS and the ELA seeks to facilitate information sharing.
- Had the PIC pilot not been used, these enquiries would have been referred straight to S1 and these same delays would have been experienced but within the context of a formal investigation, which would have increased the detriment for any doctor who may have been inappropriately referred to the GMC.

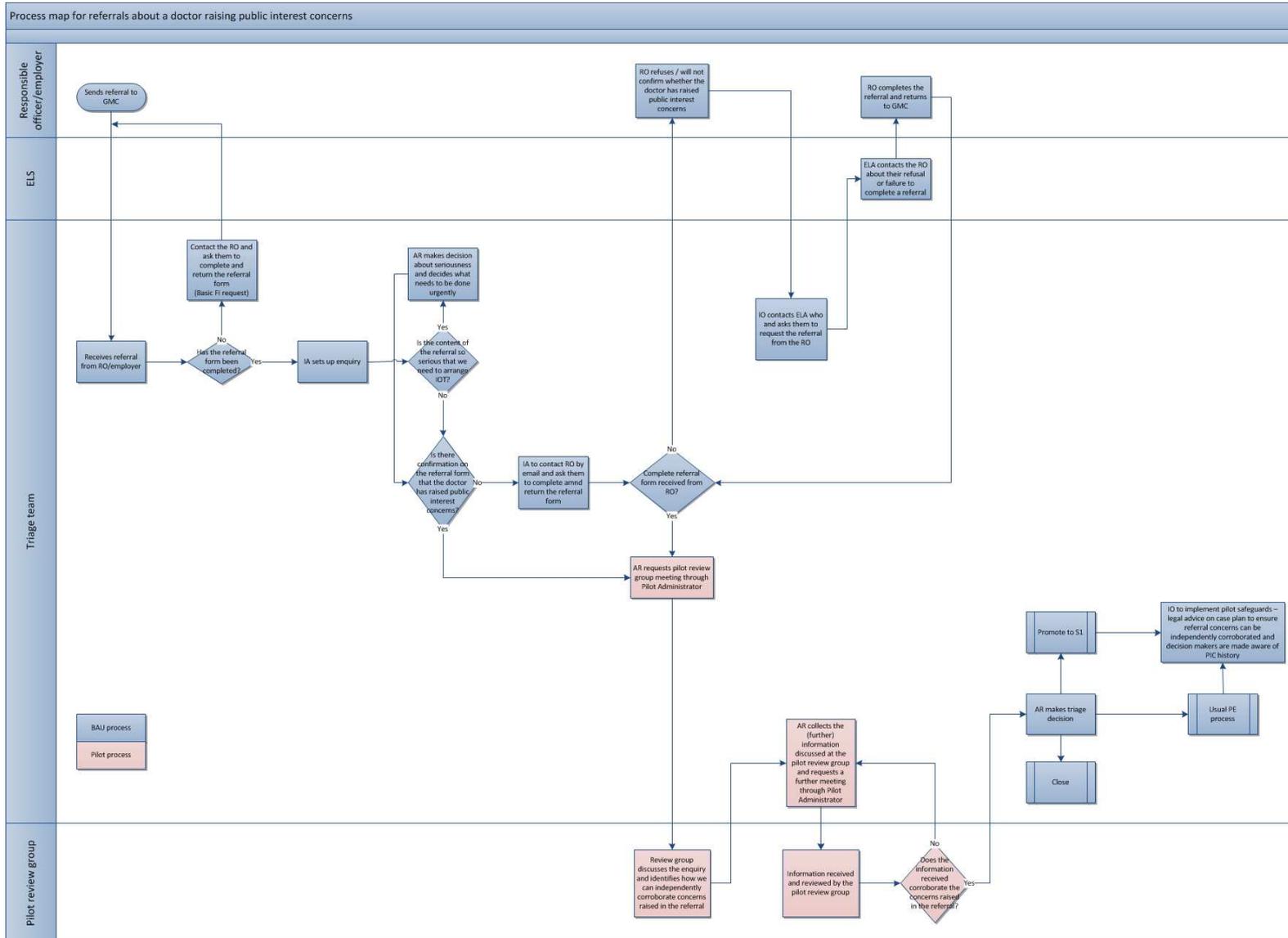
Quality

- The RO referral form is working well to facilitate the pilot and so far appears to be working to identify PIC history.
- We have taken a cautious approach for staff referring possible cases, and the Pilot Review Group provides a robust filter mechanism.
- Pilot S1 cases have had legal oversight of the case plan and detail of the whistleblowing context has been provided to

decision makers through the CARF. This includes those cases promoted to S1 where a PIC context emerged for the first time during the investigation.

- CRT was not initially identified for involvement in the pilot and we have identified that it would be useful to provide them with guidance, systems and training should a PIC context arise for the first time during monitoring.
- We have identified that it would be helpful to provide more guidance for staff about complaints about how a medical manager has handled whistleblowing both where we have had a previous referral about the complainant and where we have not, as yet, received such a referral.

Background – pilot process



Learning from pilot review group meetings

- Where we are unable to corroborate concerns raised in a referral, the pilot review group has introduced a feedback loop to the RO through the ELA. It has been agreed that the AR will include in the decision reasoning why we are providing feedback to the RO and what it should be. We are also considering feedback where a PIC context emerges that was not previously identified in the referral form.
- ELA feedback should be recorded in an SR in Siebel so that we have a clear record that this has been actioned.
- Recording detail of pilot review group discussions on each case to use as a basis for the future development of policy guidance on how to manage enquiries/cases that have a PIC context.
- Operational guidance needs to be updated to instruct staff to record any delays in the process on Siebel.
- Further guidance to be developed about complaints about an RO is received where it relates to a previous PIC referral or where we have not, as yet, received a referral. ,

Recommendations

1. Use pilot review group records to update PIC guidance to assist with assessment of referrals and identification of information to independently corroborate the concerns raised (to replace the pilot process on slide 7).
2. Review existing guidance and the PIC checklist to identify whether we can provide further focus on the referrals meeting the investigation threshold. Currently 26% of enquiries referred to the group are closed because they do not meet the threshold.
3. To review process for feedback to the RO through the ELA for enquiries/ cases that we close. To consider feedback where PIC not identified on referral form.
4. Consider a mechanism by which we can report on the feedback given to ROs to allow us to identify any patterns or themes. This could be picked up through Siebel reporting if this information was recorded in an SR.
5. There are very low volumes of referrals with a PIC context. These cases are complex and the information we receive can amount to hundreds of pages. This is unusual for the provisional enquiry process. Consider dedicated staff to support it and further training to help them deal with this type of enquiry. Could avoid impact on other PE caseloads.
6. Consider a PIC SLA. Currently these types of enquiries/cases do not meet either the PE SLA or the 6 month S1 SLA. It would be more motivating for staff dealing with this work if they could reasonably achieve targets.
7. Review PIC guidance, training and systems for the Case Review Team (CRT). CRT was not initially identified as having involvement in the pilot.
8. Review the volume of information required to assess allegations in PIC provisional enquiries. For example, in one of the PIC PEs, we have requested trust investigation reports, clinical records for multiple patients, a documented discussion, medical CE advice and a second documented discussion.
9. While the internal PIC process had not introduced any significant delays, it takes an average of 23 days to convene a pilot review group given the availability of SMT. Consider a regular standing meeting that is cancelled should there be nothing to discuss.
10. Develop a business as usual process and escalation route (to replace the pilot process highlighted on slide 7), if PIC is to progress from the current pilot status.

Annex B - Update on independent review of whistleblowing

Sir Anthony Hooper Review

Action Plan

The plan shows the recommendations from Sir Anthony Hooper’s review of how we handle cases involving whistleblowers, the action we have identified in response and indicative timeframes for completing this work.

Recommendation	Action planned	Indicative timeframe
<p>Recommendation 1: Organisations referring a doctor’s fitness to practise to the GMC should be encouraged to answer a written question the effect of which is to ascertain whether the doctor being referred has raised concerns about patient safety or the integrity of the system.</p>	<p>We will carry out a review of our guidance on how to make a referral to us to include what information organisations need to provide about doctors who have raised concerns about patient safety or the integrity of the system.</p>	<p>March 2016</p>

Recommendation	Action planned	Indicative timeframe
<p>Recommendation 2: Organisations referring a doctor’s fitness to practise to the GMC should be encouraged to have the document containing the allegation signed by a registered doctor and to contain a statement by the doctor to the effect that: “I believe that the facts stated in this document are true”.</p>	<p>As part of the review above we will discuss with responsible officers and employers how we would include a signed statement.</p>	<p>December 2015</p>
<p>Recommendation 3: If the written document containing the allegation is not signed by a registered doctor and/or does not contain a statement to the effect that “I believe that the facts stated in this document are true”, organisations should be encouraged to explain why this has not been done.</p>	<p>We will explore how we would consider the circumstance where a referring organisation did not provide any information encouraged under our guidance on how to make as referral to us.</p>	<p>June 2016</p>

Recommendation	Action planned	Indicative timeframe
<p>Recommendation 4: If a doctor being referred to the GMC has raised concerns about patient safety or the integrity of the system with the organisation making the referral, then the necessary steps should be taken to obtain from the organisation material which is relevant to an understanding of the context in which the referral is made.</p>	<p>We will carry out a review of how we currently use our powers under rule 4(4) to obtain material which is relevant to an understanding of the context in which the referral is made.</p>	<p>June 2016</p>
<p>Recommendation 5: Investigators assessing the credibility of an allegation made by an organisation against a doctor who has raised a concern should take into account, in assessing the merits of the allegation, any failure on the part of an organisation to investigate the concern raised and/or have proper procedures in place to encourage and handle the raising of concerns.</p>	<p>We will explore how we might further develop how we consider information that indicates failure of an organisation to investigate the concern raised by a 'whistleblower' and/or have proper procedures in place to encourage and handle the raising of concerns.</p>	<p>June 2016</p>

Recommendation	Action planned	Indicative timeframe
<p>Recommendation 6: In those cases where an allegation is made by an organisation against a doctor who has raised concerns, the Registrar should, where it is appropriate to do so, exercise his powers under rule 4(4) to conduct an examination into that allegation, including taking the steps outlined in my earlier recommendations and asking the doctor for his or her comments on the allegation and the circumstances in which the allegation came to be made.</p>	<p>We will explore how we can use our powers under rule 4(4) to understand the context in which a referral has been made to us where the doctor being referred may have been a 'whistleblower'.</p>	<p>June 2016</p>
<p>Recommendation 7: Those who investigate allegations made against doctors who have raised concerns must be fully trained to understand "whistleblowing", particularly in the context of the GMC and the NHS.</p>	<p>We will develop a training package for investigation staff in 2015 to enhance their understanding of 'whistleblowing'.</p>	<p>June 2016</p>

Recommendation	Action planned	Indicative timeframe
<p>Recommendation 8: The GMC, together with healthcare regulators, professional organisations, unions and defence bodies, set up a simple, confidential and voluntary online system, run by an organisation independent of the regulators. The system would enable healthcare professionals to record electronically the fact that they have raised a concern with their employers, what steps they have taken to deal with the concerns, including details of when and with whom the concerns were raised. The date and time at which the healthcare professional made the entries would be recorded. Access to the record would be restricted to the professional or another person with his or her consent.</p>	<p>We will facilitate a workshop to allow stakeholders to explore the possibility of an externally hosted and resourced voluntary online facility to record details about concerns raised by healthcare professionals.</p>	<p>December 2015</p>