To consider

Outcome of the first phase of the provisional enquiry pilot

Issue

1. A report on the outcome of the first phase of the Rule 4(4) pilot where we have been piloting the use of provisional enquiries. This paper includes an analysis of the first 100 completed provisional enquiries. It also sets out our proposals to begin an extension to the project which will focus on streamlining those investigations relating to single clinical incidents.

Recommendations

2. The Strategy and Policy Board is asked to:

  a. Note the outcomes of the first phase of the Rule 4(4) pilot – provisional enquiries.
  b. Note our plans to roll out provisional enquiries as business as usual activity.
  c. Agree to initiate a second phase of the Rule 4(4) pilot to scope and plan how we streamline the way we investigate single clinical concerns.
Outcome of the first phase of the provisional enquiry pilot

Issue

3 Between 2010 and 2013, we opened 6,174 investigations into doctors who were complained about. Of these investigations, over 83% resulted in no action being taken against the doctor*. Such investigations can cause unnecessary stress and inconvenience to the complainant, the doctor and the doctor’s employers and/or contractors. To address this, we launched a controlled pilot of the provisional enquiry process on 3 November 2014.

4 A provisional enquiry is a limited, initial enquiry at the first stage of the fitness to practise process which helps us to decide whether to open an investigation. It helps us respond more quickly and proportionately to a complaint, to accurately assess risk and avoid unnecessary investigation. During a provisional enquiry we gather one or two discrete and easily obtainable pieces of information such as medical records and/or a local investigation report. We may also seek expert medical opinion to inform our decision-making.

5 The aims of the pilot were to prove the process worked as intended, identify a meaningful service target, inform our understanding of likely future volumes and assess process effectiveness and efficiency.

6 We have now completed 103 provisional enquiries and present the findings from the pilot for consideration by the Board.

Pilot volumes and outcomes

7 In our early research we estimated that up to 500 complaints might be suitable for a provisional enquiry of which around two thirds (330) might reasonably be closed. Using the volumes received during the pilot period, our statistical forecasts suggest an average of between 1.0 and 1.4 enquiries per day. Assuming 252 working days per year, our revised forecast is between 252 and 353 provisional enquiries per year with between 176 and 247 unnecessary investigations avoided.

8 Since November 2014 we have opened 176 provisional enquiries where we believed the concerns raised had the potential to be serious but needed further information to make a more informed decision as to whether the concerns raised questions about the doctor’s fitness to practise that would require a full investigation. At the time of preparing this paper, we had completed 103 of the 176 provisional enquiries. The figures and analysis focuses on these completed provisional enquiries.

* State of medical education and practice report 2014, chapter one, p73
9 Of the 103 enquiries completed, 72 or 70% were closed. 31 or 30% were promoted for investigation with the most common reason for promotion being that we identified serious concerns in the information that we collected.

10 As part of a lessons learned exercise we carried out further analysis of the 31 provisional enquiries that were subsequently promoted for full investigation. We identified four complaints which, with hindsight, were unsuitable for the provisional enquiry process and should have been promoted for full investigation from the outset and we have included the relevant learning points within the decision-makers’ guidance, at Annex A. A summary of the findings from our review of provisional enquiries which were promoted for full investigation is at Annex B.

11 To ensure the quality of outcomes, we put a four-stage quality plan in place. Prior to the launch of the pilot, we produced guidance to help decision-makers correctly identify complaints suitable for a provisional enquiry. At the beginning of the pilot, the Fitness to Practise directorate internal audit team reviewed nine completed provisional enquiries to assess whether the early decisions made were correct and in line with current guidance and thresholds. No errors were identified and examples of good practice were highlighted for future reference.

12 Throughout the duration of the pilot, a group of senior decision-makers reviewed and approved the outcome of each provisional enquiry. Where the outcome was to promote for full investigation, the group considered whether the decision to launch a provisional enquiry was appropriate, with any learning points being added to the decision-makers’ guidance.

13 We also worked closely with colleagues within the Rule 12 team. During the course of the pilot, one closure decision was challenged and as a result the registrar’s decision has been reopened. The learning points from this review have been discussed with the assistant registrars and included within the decision-makers’ guidance.

Process duration and effectiveness

14 At the outset of the pilot we agreed to use a 42 day service target to benchmark overall process performance, focus the investigation, reduce delays if the provisional enquiry was promoted for full investigation and prevent enquiries from remaining within the process longer than necessary.

15 The average duration of the 103 completed cases was 64 days and the median was 63 days. The shortest provisional enquiry took 15 days to complete, the longest took 120 days. Using statistical forecasting we have found that the average duration of a provisional enquiry over the longer term will be between 59 and 68 days, which compares to 245 days median time for investigation.

16 Although longer than initially expected, the benefit of using provisional enquiries to consider complaints outweighs the impact of the smaller number of enquiries that are
subsequently promoted for full investigation. This is because, in such cases, we will have already obtained consent and key information, such as medical records, and this will focus the scope of the investigation on those allegations identified as being serious. The provisional enquiry process features a number of discrete stages and a breakdown of the average duration of each stage of the process is at Annex C.

17 Based on the analysis of the duration of the 103 completed provisional enquiries, we recommend that we set our provisional enquiry service target as follows:

a 75% of right first time provisional enquiries to be completed within 67 days of decision to proceed with a provisional enquiry.

b 90% of right first time provisional enquiries to be completed within 84 days of decision to proceed with a provisional enquiry.

18 To ensure that we are responsive to the process users we sought feedback from doctors, complainants and experts. Of those respondents who expressed an opinion 77% of doctors and 60% of complainants either agreed or strongly agreed that we should roll out the provisional enquiry process. Doctors and complainants suggested that we need to look into providing clearer information; both at the outset and when detailing our decision. A summary of findings from the feedback questionnaires is at Annex D.

Assessing the costs and benefits of the provisional enquiry process

19 The key benefits of the provisional enquiry process are resolving complaints quicker which reduces the impact on complainants and doctors and targets our resources on the complaints that require full investigation.

20 However, we are also responsible for ensuring that we use our resources efficiently and effectively and in view of this we assessed the cost/benefit of the new process. Assuming 353 provisional enquiries per year, we would expect to incur operational costs of £40,200 per annum including staff and expert opinion costs. We expect to make actual costs savings of £47,000 through the avoidance of full expert reports and save 815 days’ worth of staff time. Annex E summarises the cost/benefit of the new process.

21 Our analysis suggests that we would be able to allocate three investigation officers to this work who will each be able to complete 117 provisional enquiries each year. This compares favourably with the full investigation process where an experienced investigation officer is typically able to complete between 35 and 50 cases per annum (based on the number of completed cases over the last 12 months).
Roll out of provisional enquiries as business as usual activity

22. We plan to launch provisional enquiries as a business as usual process in September 2015. As the majority of staff involved in the pilot will continue to manage provisional enquiries as a business as usual activity, the roll out work will not be complex.

23. In September 2015 we will run a series of refresher training sessions for Fitness to Practise directorate staff and train out the revisions made to the guidance for decision-makers. We will also provide ongoing advice and support to our decision-makers through a twice weekly drop-in session where assistant registrars can seek advice on complex enquiries from experienced decision-makers.

24. No additional system changes will be required.

The Rule 4(4) pilot and single clinical incidents

25. Our data does not allow us to report reliably on the number of single clinical concerns we investigate but from previous sampling undertaken we believe it is between 15-20% of Stream 1. These cases can typically take around 183 to 234 days to complete with over 90% of these concluding with no further action being taken against the doctor. As such they can cause stress and inconvenience for both doctor and complainant alike and do not represent the best use of our investigation resources.

26. Proposals are being discussed at Council for enhanced triage guidance to support Employer Liaison Advisers (ELAs) to provide more robust advice to Responsible Officers (ROs) on single clinical incidents to avoid unnecessary referral of concerns that do not raise patient protection or public confidence issues. Proposals for greater access for triage decision makers to the information underpinning the ELAs’ advice to ROs when assessing patient complaints about single incidents will assist them to make more informed decisions about whether the concerns should be investigated. This work is part of a wider programme of reform to ensure that we focus our activity on those cases that require action in the public interest.

27. These changes may take time to develop, and in the meantime, we propose to run a further phase of the provisional enquiries pilot to include all single clinical incidents, unless it is clear from the information we hold that the matter should be fully investigated. Within the provisional enquiries process we would request the information from ROs that in future we would look to obtain via ELAs. In the longer term the provisional enquiries process would continue to be used to approach ROs where we receive a single incident concern from a patient where the RO has not previously discussed the matter with the ELA and for single incident concerns about doctors who do not have an RO to obtain feedback from their employers.
Supporting information

How this issue relates to the corporate strategy and business plan

28 Strategic Aim 3: to improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety.

How the issues support the principles of better regulation

29 The introduction of provisional enquiries will result in a more proportionate, targeted response to complaints received and better allocation of our resources ensuring that we do not over-promote allegations and continue to investigate thoroughly complaints that raise serious concerns about a doctor’s fitness to practise.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

30 Prior to the launch of the pilot we discussed our approach with a number of key interest groups including medical defence organisations, medical experts and ROs (through our ELAs). Our roll-out plans include activities to update external-facing documentations (such as booklets, fact sheets and web pages) which will explain how provisional enquiries fit into the wider fitness to practise process.

What equality and diversity considerations relate to this issue

31 We have analysed all of the provisional enquiries that fell within the pilot period (November 2014 to May 2015) and compared these figures with the characteristics of doctors involved within our stream one investigation process. The spread of male and female doctors involved in completed provisional enquiries and stream one investigations was very similar (72% male doctors and 28% female doctors within provisional enquiries and 75% male and 25% female within stream one investigations).

32 The number of black and minority ethnic (BME) doctors involved in completed provisional enquiries and stream one investigations were broadly similar (27% BME doctors involved in provisional enquiries compared to 32% of BME doctors involved in stream one investigations). We expect 70% of provisional enquiries to close which will benefit doctors over-represented in our procedures by reducing the need for Stream 1 investigations.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director, Policy, Business Transformation and Safeguarding, arowland@gmc-uk.org, 020 7189 5077.
Pre-triage Enquiries

Draft guidance for decision makers

1. This draft guidance outlines the approach for the triage team when deciding which cases will be suitable for pre-triage enquiries.
Pre-triage enquiries (Rule 4(4))

Introduction

1. This guidance is supplementary to the Guidance on categorising Stream 1, Notify RO and Notify Employer cases and allocating cases to the National Investigation Team and the Regional Investigation Teams. It is intended to support Assistant Registrars (ARs) in deciding whether further enquiries should be made under Rule 4(4), clarifying the situations in which it is appropriate to make further enquiries and the types of information that can be obtained.

2. Our primary function as a regulator is to protect the health and safety of the public and the public interest. We do this by assessing the risk that is posed to the public by a doctor’s impaired fitness to practise. Our response to this risk must be proportionate and targeted.

3. Making further enquiries under Rule 4(4), can assist us to respond quicker and more proportionately to accurately assessed risk in some cases, avoiding unnecessary investigation, and enabling us focus on those cases that require full investigation.

Principles

4. Rule 4(4) provides an explicit power for the Registrar (delegated to Assistant Registrars) to make further enquiries before making a decision at triage. The AR can:

   ‘…carry out any investigations as in his opinion are appropriate to the consideration of:

   a. whether or not the allegation falls within section 35C(2) of the Act;

   b. the practitioner’s fitness to practise; or

   c. the matters outlined within paragraph 5 … [Rule 4(5) the five year rule].

5. Subject to the limitations referred to below at paragraph 12, this guidance provides for the AR to make further enquiries in three situations. These are where:

   a. the allegation itself is unclear;

   b. it is unclear whether the allegation is serious enough to raise a question of impaired fitness to practice; or

   c. the allegation, on the face of it, is serious but the evidence may be unlikely to support a finding of impairment and further information is needed to clarify whether the allegation is capable of raising a question of impaired fitness to practise.
6 In relation to (a) above (i.e. the allegation itself is unclear) the AR must make sufficient reasonable enquiries to enable them to make a decision. Examples of clarification will include identifying relevant doctors, obtaining documents missing from the information received to date and/or clarification of places and dates from a complainant or referrer.

7 In relation to (b) above many allegations falling within this category are likely to be performance related. The AR can make enquiries under Rule 4(4) to clarify whether the concerns raised about a doctor’s performance would require us to conduct an investigation (because they raise a question about the doctor’s fitness to practise). This may include obtaining limited medical records, opinions from a medical Case Examiner (CE) and/or external experts.

8 In relation to (c) above, allegations based on which the evidence is unlikely to support a finding of impairment are those where, despite appearing to be serious, it seems likely that evidence, which can be easily obtained within Rule 4(4), would reveal that the allegation is unsupported and therefore not capable of raising a question of impaired fitness to practise. These allegations are often likely to involve misconduct.

9 In categories 5 (b) and (c) above, a case is suitable for Rule 4(4) if it appears likely that clarification can be achieved by obtaining one or two discrete pieces of information on the basis that the information can be obtained within a reasonable period of time. It may be appropriate to discuss these timescales with the relevant ELA.

Suitability

10 Whilst every enquiry should be considered on a case by cases basis, the AR may find it useful to bear the following principles in mind when deciding whether or not a provisional enquiry is appropriate.

11 A PE may be considered suitable where:

   a an allegation appears confused or may be based on a misperception and we can contact external sources for clarification;

   b an allegation is clear but it contains information that suggests that it may not raise questions about a doctor’s fitness to practise;

   c local or third-party investigation information is available which could help us determine whether there is a fitness to practise issue;

12 A PE is unlikely to be appropriate where:
a we have clear information from the complainant that raises a question about the
doctor’s fitness to practise that meets the threshold for a full investigation.

b the concerns are such that we would ordinarily close the case (ie. rule 4(4) should
not be used to validate a decision to close the case where the criteria for closure
are met).

c an enquiry is linked to an existing investigation, where it may be more suitable to
link the allegation to the existing case.

d the incident giving rise to the allegation predates another concluded case about
the same doctor and the concerns have been dealt with.

e there is a significant dispute about the facts or an allegation of dishonesty that can
only be resolved by establishing credibility through witness testimony or otherwise
cannot be resolved by obtaining a discrete piece of information.

f the concerns relate to systemic issues rather than fitness to practise issues.

13 Case studies illustrating the use of Rule 4(4) Pre-triage enquiries are set out at annex
A.

The test at Rule 4(4)

14 The test at rule 4(4) is not whether the realistic prospect test is met but whether the
concerns raise a question about a doctor’s fitness to practise.

15 Where the allegation is clear and/or there is sufficient information to make a decision,
the AR should make a decision to close or promote the allegation following the usual
procedure under Rule 4.

Information suitable for provisional enquiry

Medical records

16 It is acknowledged that, in the majority of clinical cases, relevant medical records will
exist. Given the timeframe within which preliminary enquiries will be conducted, it is
likely that we will ask for only limited extracts from medical records and only from
relevant sites.

17 In cases where medical records have been identified as the discrete information
necessary to make a decision under Rule 4(4), the AR, with advice from a Medical CE,
must present strong reasons why they are likely to identify or clarify the issue. The
AR must also specify and give reasons for the extent and type of medical records required.

18 The AR should always consider the following when directing that medical records should be requested:

a Are the records likely to confirm whether or not the allegations raise concerns about the doctor’s fitness to practise?

b Is there a real prospect this information could enable us to close the case?

**Oral or written enquiries with individuals/organisations**

19 These may be relatively quick enquiries that the AR (or delegated staff resource) can undertake in order to understand the nature of a complaint or referral. The Threshold guidance states:

“local enquiries may be more appropriate to establish whether the allegations arise out of a misunderstanding or whether there has been apparent misconduct by the doctor that we need to consider”*

20 In light of the arrangements for making employer disclosure we are unlikely to be able to obtain Trust reports under pre-triage enquiries unless the referral came from the Trust.

**Formal investigations by public bodies (e.g. other regulators, coroners, National Fraud Office)**

21 We may receive a complaint that concerns the outcome of a formal process. We should obtain a copy of the report if the complaint gives us reason to believe that the report will resolve issue; and the report has been produced by a credible body.

22 Given the timeframe of the preliminary enquiry process, consideration should be given to whether or not the investigation is complete and, therefore, the report available. If it is not clear from the complaint whether or not a report is available, the AR should contact the investigating body to ensure that it can be requested within the timeframe.

**Medical CE advice and Expert Opinion**

23 After obtaining medical records, or relevant third party information, an IO will need to seek either Medical Case Examiner advice, or the opinion of an external expert.

* Paragraph 13 to the Thresholds.
Where possible, the AR should indicate which is likely to be appropriate to the enquiry.

**Medical Case Examiner (CE) advice**

24 To help determine whether there is a (clinical) FTP issue that warrants investigation, a Medical CE can be asked to advise whether the doctor’s actions raise a question about their fitness to practise. It will be appropriate to request advice from a Medical CE regarding general issues or, in the case of a specialist concern, where they have the appropriate specialism.

25 At this stage, the Medical CE is not being asked to advise whether the RPT is met. The Medical CE may be asked to advise whether the standard of care ‘appears’ to be a significant issue. If the standard of care appears to be a significant issue, it is likely to form the basis of a Stream 1 decision.

**Medical expert opinion**

26 To help determine whether there is a (clinical) FTP issue that warrants investigation, the AR can ask for a medical peer opinion. The medical peer will confirm whether the complaint contains any information that suggests the doctor’s actions would warrant further enquiry.

27 It will be appropriate to refer to a medical peer for an opinion where we do not have the specialist expertise within the GMC.

28 At this stage, the medical peer is not being asked to assess the standard of care but rather whether, on the face of it, the complaint raises significant issues about the standard of care. If the medical peer is of the view that the complaint raises significant issues about the standard of care, a full investigation will be appropriate.

**Lay Case Examiner (CE) and IHLT advice**

29 To help delineate/articulate the issues within a complaint/referral, a Lay CE or IHLT can be asked for advice. At this stage, the CE or legal adviser is not being asked to advise whether the RPT is met but whether the complaint raises significant issues about the doctor that should be investigated.

**Considerations for AR**

30 The AR may be able to give some indication, based on the nature of the allegations, which of the above ought to be sought during a preliminary enquiry. The AR should consider the complexity of the allegations and the specialist input required.

31 The AR may on occasion feel it is appropriate to initially seek the opinion of a Medical Case Examiner on whether or not an expert opinion is required. This will be useful
where the AR has insufficient specialist knowledge to determine whether an external expert opinion will be useful, or what specialist input is required.

32 It may be the case that it is not possible for an AR to determine which of the above will be appropriate based on the initial allegations. Where this is the case, the decision should be deferred until the medical records have been gathered, and the IM responsible for the case will decide which option is the most appropriate.

Provisional enquiry process

Consent

33 If we propose to share sensitive information that relates to the complainant or a third party with external individuals or organisations as part of pre-triage enquiries we will need to seek consent from the complainant.

34 The online complaints form, and the PDF and Word versions of the form, ask for consent to make pre-triage enquiries. Where a complaint is made using the online form, assuming the complainant is the patient, the issue of consent will have been dealt with.

35 Where a complaint is made without using the online form, or the PDF or Word versions of the form, in light of the pressing need to ensure pre-triage enquiries are conducted quickly to enable the matter to be triaged, we will write to the complainant to seek consent to disclose the information contained in the complaint and ask for a response by a date specified.

36 If the complainant has not responded by the date provided in the letter, the information can be shared in order to facilitate pre-triage enquiries.

37 If the complainant refuses consent (including in the online form, PDF or Word version) our normal process for cases where consent is refused applies. We will need to consider any reasons provided by the complainant for refusing consent and decide whether there is justification to override the refusal to provide consent in the circumstances. If there are no good reasons to override refusal of consent, the case should be assessed based on the information we currently hold and a triage decision made. If there is justification to override refusal of consent, the information may be shared for the purpose of making pre-triage enquiries.

38 If the complaint has been referred by a Trust and contains sensitive information, our usual consent policy applies. We should contact the Trust in relation to consent. If the referral contains sensitive information about multiple (3 or more) patients we can conduct pre-triage enquiries simultaneously with contacting the Trust to ask if consent has been provided to share the information.
Disclosure

39 The doctor should be notified before we conduct any external enquiries.

40 The Fitness to Practise Rules also require us to notify a doctor’s employer as soon as reasonably practicable after a decision to investigate has been made under Rule 4(4)(a) or (b)*.

41 As with complainant consent, doctor and employer disclosure must be completed within the relevant timeframe.

* S35A(2) of the Medical Act and Rule 13 of the Fitness to Practise Rules
Annex A

Case studies

Case study one - performance
We receive an anonymous complaint from a doctor. He recommended treatment for his patient and referred him to the appropriate hospital consultant. The doctor alleges that the consultant prevented his patient from receiving the appropriate treatment and, as a result, the patient died. The complainant mentions that an inquest has been held.

The complaint raises potentially serious concerns about the consultant’s practice. Before making the decision to investigate, the AR requests the coroner’s report. The coroner’s findings show the consultant was not to blame for the patient’s death.

The case is closed at triage.

Case study two - misconduct
A health professional (Mr X) alleges that a doctor has spread false rumours about him (ie Mr X) having an affair with a patient, Ms A. Mr X also alleges that the doctor has exposed himself to a patient.

The allegation of exposing himself is serious enough to raise a question of impairment. However, the apparent vexatious nature of the allegation prompts the AR to make pre-triage enquiries to assess whether it is likely that the allegation would be supported by evidence and therefore capable of raising a question about impaired fitness to practise.

The AR checks whether we have received any information about the alleged affair with patient Ms A and finds we have received a referral from the Trust following their own investigation. The AR obtains a report of the local investigation into the alleged assault and allegation of exposure.

This report clarifies that there is no evidence to support the allegation against the doctor and that the doctor has moved practice.

As there is no evidence to support the allegation of exposure and the incident has been resolved at local level, the case is closed at triage.
Provisional enquiries which were subsequently promoted

About this annex

1. During the pilot we promoted 31 provisional enquiries for full investigation. We analysed these cases as part of our lessons learned activity. This annex provides a summary of our findings.
<table>
<thead>
<tr>
<th>Count of provisional enquiries</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 of 31</td>
<td>After obtaining medical records we identified serious concerns about the doctor which required further investigation</td>
</tr>
<tr>
<td>Four of 31</td>
<td>After obtaining the outputs from local investigation procedures we identified serious concerns about the doctor which required further investigation</td>
</tr>
<tr>
<td>Three of 31</td>
<td>Through the provisional enquiry we found that more than one doctor was involved in the incident(s) which justified further investigation</td>
</tr>
<tr>
<td>Three of 31</td>
<td>Delays in receiving information promptly from other organisations (with investigatory responsibilities) meant that it was prudent for us to launch a full investigation</td>
</tr>
<tr>
<td>Three of 31</td>
<td>Through provisional enquiries we were able to scale down the scope of full investigations (by concluding baseless allegations and removing doctors who were incorrectly identified by the complainant)</td>
</tr>
</tbody>
</table>

Please note that more than one theme can be applied to a single provisional enquiry.
### Additional learning points

<table>
<thead>
<tr>
<th>Clinical negligence cases where both parties have commissioned expert reports are unlikely to be suitable for provisional enquiries</th>
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</thead>
<tbody>
<tr>
<td>Complaints involving claims of dishonesty are unlikely to be suitable for provisional enquiries</td>
</tr>
<tr>
<td>Where the primary source of information is another regulatory body, enquiries should be made of the investigating body to determine whether the information is likely to be available within the required time period</td>
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</tbody>
</table>
6 - Outcome of the first phase of the provisional enquiry pilot

Breakdown of the average duration of each stage of the provisional enquiry process

About this annex
1 The provisional enquiry process can be broken down into a number of discrete stages. This diagram provides a breakdown of the average duration of each stage of the process.
Average provisional enquiry process duration between 59 and 68 days

- Disclosure consent: 16 days
- Medical records (MR) consent: 8 days
- Disclosure and MR consent: 13 days
- Doctor disclosure: 10 days
- Medical records from GP: 13 days
- Medical records from hospital: 21 days
- Medical records from care home: 21 days
- Local investigation/complaint details: 22 days
- Employer disclosure: 3 days
- Expert Opinion: 16 days
- Case Examiner closure advice: 3 days
- Processing closure decision: 3 days
6 - Outcome of the first phase of the provisional enquiry pilot

Summary of feedback from doctors and complainants on the provisional enquiry process

About this annex

1 We sought feedback from the process users on the provisional enquiry process. The diagrams provide a breakdown of the questions we asked about each stage of the process.
Response to 'How far do you agree that our initial letter informing you of the provisional enquiry was clear about the process and what it would involve?'

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<thead>
<tr>
<th></th>
<th>Doctor</th>
<th>Complainant</th>
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<tbody>
<tr>
<td>Strongly Agree</td>
<td>23%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Agree</td>
<td>44%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Disagree</td>
<td>23%</td>
<td>25%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>10%</td>
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Response to 'If you saw the leaflet, how helpful was it?'

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<th></th>
<th>Doctor</th>
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</thead>
<tbody>
<tr>
<td>Very helpful</td>
<td>17%</td>
<td>31%</td>
</tr>
<tr>
<td>Quite helpful</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td>Not very helpful</td>
<td>29%</td>
<td>23%</td>
</tr>
<tr>
<td>Not helpful at all</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>Did not receive</td>
<td>9%</td>
<td>0%</td>
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Response to 'How far do you agree that the requirements to provide further information/complete the work details form were clearly explained?'

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<thead>
<tr>
<th></th>
<th>Doctor</th>
<th>Complainant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>29%</td>
<td>18%</td>
</tr>
<tr>
<td>Agree</td>
<td>51%</td>
<td>71%</td>
</tr>
<tr>
<td>Disagree</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>12%</td>
<td>6%</td>
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Response to 'How satisfied were you that we handled communication with your employer(s) / contractor(s) effectively?'

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<thead>
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<th></th>
<th>Doctor</th>
<th>Complainant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>14%</td>
<td>25%</td>
</tr>
<tr>
<td>Satisfied</td>
<td>48%</td>
<td>44%</td>
</tr>
<tr>
<td>Dissatisfied</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>24%</td>
<td>19%</td>
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</table>
Response to 'How far do you agree that the GMC kept you informed of the progress of the provisional enquiry?'

<table>
<thead>
<tr>
<th></th>
<th>Doctor</th>
<th>Complainant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>Agree</td>
<td>28%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Disagree</td>
<td>23%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>31%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Response to 'How far do you agree that the decision was clearly stated and the reasons for it were clearly explained in the letter?'

<table>
<thead>
<tr>
<th></th>
<th>Doctor</th>
<th>Complainant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>26%</td>
<td>5%</td>
</tr>
<tr>
<td>Agree</td>
<td>26%</td>
<td>12%</td>
</tr>
<tr>
<td>Disagree</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>32%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Response to 'How far do you agree that the GMC conducted the provisional enquiry in a timely manner?'

<table>
<thead>
<tr>
<th></th>
<th>Doctor</th>
<th>Complainant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>21%</td>
<td>7%</td>
</tr>
<tr>
<td>Agree</td>
<td>34%</td>
<td>47%</td>
</tr>
<tr>
<td>Disagree</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>29%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Response to 'How far do you agree that the GMC should continue to carry out provisional enquiries in the future?'

<table>
<thead>
<tr>
<th></th>
<th>Doctor</th>
<th>Complainant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>33%</td>
<td>40%</td>
</tr>
<tr>
<td>Agree</td>
<td>45%</td>
<td>20%</td>
</tr>
<tr>
<td>Disagree</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>17%</td>
<td>40%</td>
</tr>
</tbody>
</table>

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6 - Outcome of the first phase of the provisional enquiry pilot

Cost and benefit analysis
<table>
<thead>
<tr>
<th>Description of benefit opportunity</th>
<th>Current FTE if applicable</th>
<th>FTE reduction if applicable</th>
<th>Budget reduction target (years 1 and 2)</th>
<th>Baseline savings</th>
<th>Calculations and rationale</th>
<th>(Cost)/ Saving £</th>
<th>Timescales for delivery</th>
<th>Project delivery costs £</th>
<th>Detail of costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in the number of full expert reports required</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>£94,324</td>
<td>Provisional enquiry has been running since January 2015. Summary as follows: 1. Each year we will carry out 353 provisional enquiries. 2. 38% of these enquiries (134) will require expert opinion. 134 provisional enquiries incurring additional costs of £300 per expert opinion. 103 of the 134 cases will be closed avoiding the need for a full expert report (costs vary by specialism). Total saving per year 47,162.</td>
<td>-40,200</td>
<td>The pilot has been running since November 2014. We have already seen a number of closures already (reducing the amount spent on expert reports). The process will be rolled out across the directorate following the Strategy and Policy Board meeting.</td>
<td>Changes to our case management system were delivered in house in 2014. Existing investigation resource has been used throughout the pilot so no additional staffing costs incurred.</td>
<td>N/A</td>
</tr>
<tr>
<td>Non Cashable Benefits</td>
<td>Measure of benefit (size quantity etc.)</td>
<td>Calculations and rationale</td>
<td>Units</td>
<td>Timescales for delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff time savings as a result of a reduction in the number of cases put through to Stream 1</td>
<td>Number of staff days that can be reallocated to the most serious fitness to practise cases</td>
<td>The average amount of staff time spent on an investigation that end in closure/closure with advice 3.3 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assumed number of unnecessary investigations avoided following completion of a provisional enquiry 247 investigations</td>
<td></td>
<td>247 investigations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total number of staff days saved 815 days</td>
<td></td>
<td>815 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Fitness to Practise Directorate**

**Business Transformation**

**Provisional Enquiry (Rule 4(4))**

**Provisional Enquiry benefits**

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