To consider

Pre-triage Enquiries (Rule 4(4))

Issue

1 The introduction of pre-triage enquiries, using investigation powers under Rule 4(4) of the General Medical Council (Fitness to Practise) Rules 2004 (as amended), to support more robust triage decisions.

Recommendations

2 The Strategy and Policy Board is asked to:

   a Agree the general approach as outlined in this paper.

   b Approve the guidance for deciding which cases will be suitable for pre-triage enquiries, at Annex A.

   c Note that a detailed implementation plan will be considered by the Performance and Resources Board at its meeting on 8 September 2014.
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Issue

3 In April 2012, Field Fisher Waterhouse (FFW) audited a sample of 100 GMC cases closed at the investigation stage of the Fitness to Practise (FtP) procedure. The audit recommended, among other things, expanding the scope of investigations under Rule 4(4). The provisions of Rule 4(4) are outlined at paragraph 4 of Annex A.

4 From their audit, FFW identified that Rule 4(4) was under-utilised as an opportunity to decide whether to close the case or open a Stream 1 investigation.

5 FFW suggested introducing a limited, further investigation stage before the Rule 4(2) decision (whether the allegation raises an impairment issue). This could lead to more robust triage decisions and prompt, appropriate referrals to Stream 1 and Stream 2.

Lean review

6 In 2013, a Lean review of triage looked at closed cases in Stream 1 and 2. A sample of Stream 1 cases was analysed. This showed that 23 (79%) of the 29 national investigation team and 67 (46%) of the 145 regional investigation team samples were closed on the basis of one or more documents that could have been obtained by the Assistant Registrar (AR) under pre-triage enquiries. It is important to note that this review was conducted with the benefit of hindsight and at the triage stage it may not always be easy to identify those cases that could be closed early following basic pre-triage enquiries. Nonetheless, there is clearly value from pre-triage enquiries of which we are not currently taking full advantage.

7 The Lean review team recommended a full roll-out of an expanded Rule 4(4) process covering all complaints identified by the AR as appropriate for the process.

Current triage approach

8 Rule 4(4) is already used at triage to obtain doctor’s identification, missing documents and/or clarification of place and dates from complainants or

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1 The audit sample consisted of 25 cases closed at enquiry stage, 25 closed following Stream 2 investigation and 50 closed following a Stream 1 investigation.
Proposed expansion of pre-triage enquiries

9 It is proposed that cases would be subject to pre-triage enquiries under Rule 4(4) in three circumstances:

a The allegation itself is unclear.

b It is unclear whether the allegation is serious enough to raise a question of impaired fitness to practise.

c The allegation is serious enough to raise a question of impaired fitness to practise but, because of the limited information available to us, we are not sure whether the allegation is patently groundless.

10 We already make further information requests where the allegation is unclear.

11 In the two new situations (paragraphs 9a and 9b above), we propose that:

a Further investigation will be limited to requesting one or exceptionally two pieces of discrete information and/or clarification from the relevant Employer Liaison Adviser (ELA).

b The AR will identify the piece of information required to clarify whether the matter raises a question of impaired fitness to practise.

c The AR will have assessed that the information is likely to be obtained within a specified timeframe.

12 In some circumstances, it may be appropriate to obtain more than one piece of information, subject to an assessment by the AR that all the required information is likely to be obtained within a specified timeframe. However, it is critical that pre-triage enquiries do not extend into investigating multiple factors. This would duplicate a Stream 1 investigation and seek to avoid the statutory framework for Stream 1 decision making.

13 This approach is reflected in the draft guidance, at Annex A. This includes a non-exhaustive list of the type of information to be requested at the expanded pre-triage stage, e.g. medical case examiner opinions; external peer opinions; limited extracts from medical records; a coroner’s report; or a local NHS Trust or independent investigation report.

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2 Triage analysis of further information requests between 13 January and 7 February 2014
Also included in the draft guidance are cases studies illustrating the benefit and purpose of expanded pre-triage enquiries.

Changes to SIEBEL

Changes to SIEBEL to support an extension to pre-triage enquiries have been planned. The current schedule is for the SIEBEL changes to be introduced in release 7.5, due at the end of August 2014.

Risk assessment

There are a number of risks involved in extending our use of pre-triage enquiries. The proposed model seeks to mitigate these risks as set out below.

a Adding delay to the investigation process.

Time limits set out in SLAs for use of the expanded pre-triage enquiry will focus the investigation.

b Failure to limit the investigation resulting in complex investigation being conducted outside the statutory framework.

The guidance, which will limit enquiries to one (or at the most two) pieces of information which the AR considers can be obtained within a specified time limit, will mitigate this risk. As will the involvement of Case Examiners and/or our in house legal team in assisting Investigation Officers to develop a streamlined investigation plan.

c Risk of missing critical evidence normally revealed by Stream 1 investigation.

The criteria for extended pre-triage enquiries set out above will ensure that this process is not used to conduct complex investigations outside the statutory framework.

d Inappropriate closure of complaint.

The use of expanded pre-triage enquiries will support more robust triage decisions and should reduce the risk of inappropriate closure of a complaint.

Consent and disclosure

The Fitness to Practise Rules require us to notify a doctor’s employer as soon as reasonably practicable after a decision to investigate. We have received legal advice confirming that this position also applies to pre-triage enquiries under Rule 4(4).

Where we wish to share the complaint with other parties we would also need to seek consent from the complainant (where we have not already received
We have been advised that it would be proportionate to minimise delay in these cases by giving complainants 14 days to provide consent (or object) to disclosure of the complaint.

19 We will introduce service targets for doctor and employer disclosure to support an effective process.

Next steps

20 A cross-directorate team is working on the implementation plan which will be brought to the Performance and Resources Board for approval at its meeting on 8 September 2014.

21 We have also established an enquiry review group to inform operational planning and finalise the detail of the business process. If any changes to the decision-makers’ guidance are required as a result of findings from this group, we will submit the amended guidance to the Performance and Resources Board together with the implementation plan in September 2014.

22 Between July and August 2014, operational manuals will be finalised and staff training will take place.

23 The new procedure is likely to be launched as a pilot in September 2014 and will be evaluated in early 2015.

Equality and Diversity

24 We have analysed Stream 1 cases that were closed with no further action over the past year (between May 2013 and April 2014). Male doctors, black and minority ethnic (BME) doctors and international medical graduates (IMGs) were all overrepresented in this analysis (compared to the number of these doctors on the register).

25 The use of the Rule 4(4) power to conduct an extended investigation will lead to earlier, more robust triage decisions. We expect our modelling exercise will show that a percentage of cases that would previously have been closed at the end of a Stream 1 investigation will now close at triage stage. This should reduce the disadvantage doctors who are overrepresented in these cases currently face.
Supporting information

How this issue relates to the corporate strategy and business plan

27 Plans to expand the use of Rule 4(4) will support 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

28 The introduction of pre-triage enquiries will result in a more proportionate, targeted response to complaints received. More robust triage decisions will result in 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.

How the action will be evaluated

29 We plan to evaluate the success of the new process no less than three months after the go-live date (22 September 2014). This will enable us to gather information on a number of enquiries that have been through the new process and consider them with reference to the risks outlined in this paper.

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

30 An internal stakeholder engagement plan has been drafted. Workshops have been held with relevant staff, including members of the triage, investigations, management information and HR team.

31 The implementation plan will include a Communications Plan to include engagement with key interests including the medical defence organisations.

What equality and diversity considerations relate to this issue

32 Between May 2013 and April 2014, 1779 Stream 1 cases were closed with no further action. Comparing this data to the numbers of doctors on the register at 11 June 2014, 74% (1312) of doctors in these cases were male as compared to 56% on the register. 37% were BME doctors compared with 28.7% on the register. And, 36% were IMGs compared with 26.1% on the register.

33 We consider that this initiative will benefit doctors over-represented in our procedures by reducing the need for Stream 1 investigations in some cases.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director - Policy and Planning, 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 and Stream 2 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 ARs) 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 11, the AR can use the power 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 enough to raise a question of impaired fitness to practise but, may be patently groundless 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 the first situation, ie 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 Most allegations falling within the second category, ie where it is unclear whether the allegation is serious enough to raise an issue of impairment, 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, in the event that we do not have the relevant experience in-house, external expert opinions. At this stage, we would not be seeking an expert report on the doctor’s performance but on whether the allegation warrants further investigation.

8 By allegations that may be patently groundless, we mean 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 unfounded and therefore not capable of raising a question of impaired fitness to practise. These allegations are most 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, exceptionally, two discrete pieces of information and/or seeking clarification from the relevant ELA, and that the information can be obtained within a reasonable period of time.

10 Case studies illustrating categories 5(b) and 5(c) are set out at Annex A.

11 Please note that rule 4(4) does not permit the AR to:

a conduct a Stream 1 investigation at triage;

b establish impairment, or whether the RPT is met;

c to settle disputed facts; or

d undertake further enquiries in every case.
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. [A decision flow chart is attached at
Annex A.]

Consent

13 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.

14 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, the issue of consent will have been dealt with.

15 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.

16 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.

17 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.

18 If the complaint has been referred by a Trust and contains sensitive
information, our usual consent policy applies. This means we can conduct pre-
triage enquiries simultaneously with contacting the Trust to ask if consent has
been provided to share the information.

Disclosure

19 The doctor should be notified before we conduct any external enquiries.
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)\(^1\).

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

**Examples of information suitable for pre-triage enquiry**

*Medical Case Examiner (CE) advice*

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 were reasonable and indicated in the circumstances. It will be appropriate to ask a Medical CE regarding general issues or, in the case of a specialist concern, where they have the appropriate specialism.

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

The Medical CE may suggest that a medical expert opinion (see below) is needed. If the CE does, they should set out reasons for this advice and suggest the specialty of the medical expert. A medical expert opinion should not be sought without the agreement of the Medical CE.

*Medical expert opinion (if the Medical CE advises)*

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 may be inappropriate such that would warrant further enquiry. It will be appropriate to refer to a medical peer for an opinion where we do not have the specialist expertise within the GMC.

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.

\(^1\) S35A(2) of the Medical Act and rule 13 of the Fitness to Practise Rules
Medical or Lay Case Examiner (CE) and IHLT advice

27 To help delineate/articulate the issues within a complaint/referral, a Medical or 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.

Oral or written enquiries with individuals/organisations

28 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.”

29 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.

Medical records

30 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.

31 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.

Formal investigations by public bodies (eg other regulators, coroners, National Fraud Office)

32 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.

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2 Paragraph 13 to the Thresholds.
Case studies

Case study - 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 - 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 patently groundless.

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 serious allegation of exposure and the incident has been resolved at local level, the case is closed at triage.
Annex B

Rule 4(4) decision flowchart

Rule 4(4) decision flowchart

Is the allegation about a registered doctor? If no, close
If yes, do you have sufficient, clear information to understand what is alleged?

Yes

Is there sufficient information to understand whether the allegation is serious enough to raise an issue of impaired fitness to practise?

No

Yes

Do I have any reason to believe that the allegation is groundless?

IE is there any reason to believe the allegation may be vexatious?

AND/OR could a key element in the allegation be easily verified?

Eg is there one document or a report that can be checked.

Yes

Make decision to carry out preliminary investigations under rule 4(4) stating clearly the reasons for doing so, the information that is required and how long this will take to obtain.

No

Allegation clarified, sufficiently serious and not groundless

Clear, serious allegation but groundless

Allegation clarified – not serious

Allegations that after 4(4) are still either unclear or insufficient information to know whether it is serious

PROMOTE TO INVESTIGATION

REVIEW AND DECISION BY SENIOR STAFF

CLOSE