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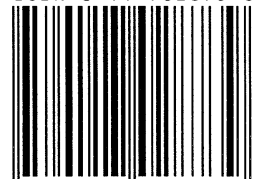
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Investigation into issues arising from the case of Loughborough GP Peter Green - August 2001

Investigation

Investigation into issues arising from the case of Loughborough GP Peter Green



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Executive summary

1. On 10 July 2000 Peter Green, a GP from the Pinfold Gate practice in Loughborough was convicted on nine counts of indecent assault on five patients. The conviction was the culmination of concerns raised over a period of twelve years and followed three separate police investigations. Files of evidence for the first two investigations in 1985 and 1993 were submitted to the Crown Prosecution Service (CPS) but neither of these resulted in further action.

2. In 1989 Peter Green developed a research proposal for a *back project*, which included young adults. He advised his partners that he had received two year funding from the University of Loughborough for the project, but the project continued well into 1997. It subsequently emerged that some minors were included in the patients studied.

3. Between 1985 and 1997 patients had tried to raise concerns with the family health service authority (FHSA), with the doctors at the Pinfold Gate practice, with the police and officer(s) of the General Medical Council (GMC) about the nature of their consultations with Peter Green. It was not until June 1997 that action ensued when the medical director of the Fosse Healthcare Trust (community trust) contacted Leicestershire Health Authority to register concern. A health visitor, who raised concerns with the practice on two occasions, in 1996 and again in 1997, triggered the action. On each occasion she had discussed her concerns with her line manager at the community trust. We commend the health visitor for her action, which led to Peter Green being referred to the GMC in July 1997 by the health authority, and ultimately to his conviction.

4. Because of the seriousness of the issues, and the fact that they continued over a long period of time, the secretary of state for health invited the Commission for Health Improvement (CHI) to undertake an investigation. The focus of the investigation was the examination of systems and procedures, although it was recognised that some discussion about individual roles and responsibilities would occur.

Acknowledgement

5. We are aware that the events leading to the conviction of Peter Green have caused considerable and continuing distress to a number of young adults. During the period of time that our investigation covered (1977-1998) patients who had tried to raise their concerns were left powerless in their discussions with professionals and managers, and have not been acknowledged for speaking up. We are therefore especially grateful to them for speaking to us and for their contribution to this report.

Key findings

Complaints

6. An NHS culture that did not listen to, or treat complaints inquisitively. The way in which NHS staff and patients related their experience to CHI described a system which allowed *a credible person to do incredible things to patients to whom he had a duty of care*.

7. An NHS complaints system failing to detect issues of professional misconduct or criminal activity.

Management and accountability

8. Greater clarity about the accountability of GPs for the quality of patient care, both individually and collectively is required as are explicit arrangements for monitoring practice.

9. Within clinical governance arrangements there needs to be clear distinction between unintentional poor performance and areas of professional misconduct and criminal activity. Other high profile cases, for example, Harold Shipman and Rodney Ledward, reinforce the importance of this distinction, and the difficulties of detection within the current system.

10. Huge energy and commitment in Leicestershire to developing and raising standards within primary care. This was coupled with frustration that health authorities are required to account for quality with no direct line accountability between health authorities and general practice. Health authorities are also limited in the scope of monitoring and audit that can be specified within general practice.

11. Concerns raised with CHI that where a doctor is removed from the medical register there is nothing currently within the regulatory framework to prevent the individual from practicing in another profession, for example, psychotherapy, hypnotherapy.

Quality of patient care

12. The lack of overview and co-ordination of concerns as they emerged to trigger warnings.

13. The weakness of a system where there is little peer review and monitoring of organisation practice, for example appointment systems, and clinical practice to assure quality in general practice. While a 'sexual conduct protocol' was put in place by practice partners in response to concerns about Peter Green's *back project*, and agreed by all partners, no formal mechanisms were established to audit practice, for example, chaperoning of patients, audit of patient notes.

14. The need for a fast track process within the General Medical Council so that cases at the extreme end of professional misconduct can be dealt with swiftly.

Research in the NHS

15. No means of identifying individual clinicians who may be engaging in unapproved research projects. Thus the purpose for which local research ethics committees was established, that is to protect the interests of patients participating in research projects, have no value should a professional choose not to follow agreed procedures.

Communication

16. There was a lack of common understanding of the full events surrounding Peter Green when the issues first came to light in 1997. In such a high profile situation, this created difficulties for the health authority in ensuring consistent communication with the public and with staff in direct contact with patients.

17. Anxiety on the part of patients and staff about the role and purpose of the health authority's help line suggests that a national handbook for the NHS, providing guidelines on the establishment of help lines would be timely.

Next steps

18. Recommendations to address the concerns found are outlined in chapter 5 of the report.

Introduction

Background

1.1 On 10 July 2000 Peter Green, a GP from the Pinfold Gate practice in Loughborough, was convicted on nine counts of indecent assault on five patients. The conviction was the culmination of concerns raised over a period of 12 years and followed three separate police investigations. Files of evidence for the first two investigations in 1985 and 1993 were submitted to the Crown Prosecution Service but neither of these resulted in further action.

1.2 In 1989 Peter Green developed a research proposal for a *back project*, which included young adults. He advised his partners that he had received two year funding from University of Loughborough for the project, but the project continued well into 1997. It subsequently emerged that some minors were included in the patients studied.

1.3 Between 1985 and 1997 patients had tried to raise concerns with the Family Health Service Authority (FHSA), with the doctors at the Pinfold Gate practice, and with the police about the nature of their consultations with Peter Green. It was not until June 1997 that action ensued when the medical director of the Fosse Healthcare Trust (community trust) contacted Leicestershire Health Authority to register concern. This action was triggered by a health visitor who had raised concerns with the practice on two separate occasions in 1996 and 1997, and on each occasion discussed it with her line manager at the community trust. We commend the health visitor for her action, which led to Peter Green being referred to the General Medical Council (GMC) in July 1997 by the health authority, and ultimately to his conviction.

1.4 As the GMC investigation took some time to proceed, the health authority also made an application to the NHS tribunal on 7 November 1997 to remove Peter Green from their medical list pending the outcome of the GMC investigation. The NHS tribunal agreed interim suspension from the health authority medical list on 11 March 1998. An order of interim suspension from the medical register was granted by the GMC on 2 June 1998.

1.5 The health authority did not have the legal power to suspend Peter Green and was unable to persuade him to discontinue practice, pending the outcome of the NHS tribunal hearing and GMC investigation. Thus as his partners, on legal advice, had dissolved the practice partnership on 31 July 1997, Peter Green continued to practice as a single handed practitioner, and as a member of the out of hours service between 31 July 1997 and 11 March 1998, a total of eight months.

1.6 The events as they unfolded and impacted on the Pinfold Gate practice, of which Peter Green had been a partner, generated confusion, speculation and anxiety for practice patients, practice staff and others in the community. As details emerged, many people were surprised both that he could continue to practise, and to continue to practise on his own.

1.7 It was almost 12 months from the date of his referral to the GMC in July 1997 before the police were able to bring charges of indecent assault on several patients against Peter Green, and a further 18 months before his trial.

Acknowledgement

1.8 We are aware that the events leading to the conviction of Peter Green have caused considerable and continuing distress to a number of young adults. During the period of time that our investigation covered (1977-1998) patients who had tried to raise their concerns were left powerless in their discussions with professionals and managers, and have not been acknowledged for speaking up. We are therefore especially grateful to them for speaking to us and for their contribution to this report.

Terms of reference

1.9 Because of the seriousness of the issues, and the fact that they continued over a long period of time, the secretary of state for health invited the Commission for Health Improvement (CHI) to undertake an investigation. The terms of reference required CHI to consider NHS accountability and management arrangements in place in Leicestershire between 1977 and 1998. Over this period complex arrangements were in place. In addition, these arrangements were frequently changing. Detailed background information is attached as appendix A to assist understanding of these arrangements. The information includes, for example, an explanation of the independent contractor status of GPs, the roles of organisations such as the family practitioner committee (FPC) and their successor organisation the FHSA, and complaints procedures in place during this period. The terms of reference were:

The Commission should investigate:

- 1. The management, provision and quality of health care provided by the former Loughborough GP, Peter Green, under arrangements with Leicestershire Health Authority, in particular the issues raised by the indecent assaults on the patients of Peter Green, between 01.07.77 and 11.03.98 and the systems underpinning this.*
- 2. The role and conduct of the persons and bodies involved in the management of health care provided by Peter Green, in particular:*

(a) Leicestershire Health Authority's arrangements for:*

- *Monitoring and improving the quality of general medical services for which it is responsible;*
 - *Monitoring and improving the quality of other health care provided to the local population, in particular children and young people, in its area by general practitioners under arrangements with the authority;*
 - *Procedures for handling and addressing complaints and concerns raised about the quality of health care provided by general practitioners in their area, including concerns raised by individual patients, and their procedures for the referral of such concerns to the appropriate persons or bodies, including the General Medical Council;*
 - *Arrangements for managing the impact of the medical research projects carried out by Peter Green on the quality of the health care provided to his patients.*
- (b) The role of the general practitioners practising in partnership with Peter Green between 01.07.77 and 31.07.97 including their role in ensuring appropriate policies and procedures are in place to safeguard the interests of patients and clinicians.*
- (c) The role of the Trent regional office of the NHS Executive and, prior to 1 April 1996, the Trent regional health authority, in performance managing the provision and quality of primary care.*

** Including arrangements in place with the family health service authority prior to their abolition.*

1.10 The focus of the investigation was on the examination of systems and procedures. It was recognised that some discussion about individual roles and responsibilities would occur but this would be in the context of understanding those roles and responsibilities. The approach accords with CHI's function to examine and analyse system failure.

1.11 Thus it was not significant to the investigation that Peter Green was given leave to appeal against his conviction. The issue for CHI was not whether he was guilty or not guilty of the offences for which he was convicted but whether systems were in place that could have detected the abuse of patients and prevented it from continuing. Equally, the referral of certain matters relating to Peter Green's former partners to the GMC did not affect CHI's remit.

Team membership

1.12 An investigating team appointed by CHI, was drawn from the NHS outside the geographical area of the Trent region. Full members of the team were: a chief executive, a general practitioner, a practice nurse, a practice manager, and a lay member with experience of working on patient and public involvement issues. An investigations manager, employed by CHI, managed the investigation, supported by a second investigations manager and investigations co-ordinator. An external adviser was appointed to provide input on prescribing issues. CHI's director of nursing oversaw the investigation. Team membership details are provided at appendix B.

Team approach

1.13 The aim was to establish facts, report on findings and make recommendations for action, which would restore public confidence and improve the quality of service in general practice. While seeking to be supportive, it was agreed that where CHI found failings these would be robustly reported. The objective was to learn lessons about how best to ensure patient safety and good patient care both for the benefit of people living in Leicestershire and for the NHS as a whole.

Method of working

1.14 Information was made available to CHI from which key topics for the investigation were identified. During the investigation further information was collected through interview and documentary analysis. The CHI team met regularly to share information and identify key findings. This allowed information obtained in interviews and the documentary evidence to be cross checked. Appendices C-E detail sources of information and the methods used. A visit to the Pinfold Gate Health Centre in Loughborough, where Peter Green was a practising GP, was also undertaken.

Contact with patients and the public

1.15 Contact with patients and with the public was integral to the investigation and their views are reflected throughout the report. Two approaches were used:

- meetings were held with people living and working in the area who were not part of the formal investigation. We call these stakeholder meetings. The purpose of the meetings was to provide an opportunity for people working in or with the local NHS, or people with an interest in it, for example patients, relatives, voluntary sector representatives, to comment on issues they believed were relevant to the investigation.

- interviews with patients and families directly affected by events triggering the CHI investigation were planned and held separately. A steering group was established to advise on the process. The protocol and membership of the steering committee is attached as appendix F.
- an analysis of a review of the health authority's complaints handling, views obtained during our meetings with stakeholders and contacts with patients and families is attached as appendix G.

Structure of this report

1.16 This report is structured in five main chapters:

- *Introduction* - outlines the scope of the investigation, membership of the CHI team and its approach to the investigation
- *Events triggering the CHI investigation* - describes the concerns raised and the way in which they were dealt with
- *Could the abuse have been detected* - discusses whether systems were in place, which could have detected the abuse and prevented it from continuing
- *Could the abuse happen again?* - examines current arrangements in place for managing and monitoring the quality of patient care within general practice
- *Putting the jigsaw together* - discusses relevant national policy as a link to the main findings of CHI, together with recommendations for action and an outline of the next steps

2 | Events triggering the CHI investigation

2.1 In this chapter we consider:

- The *back project* undertaken by Peter Green, patient concerns and the organisations involved in dealing with those concerns
- The management of the impact of the *back project* on local services and conclude with a discussion about key issues for further consideration

The *back project* undertaken by Peter Green, patient concerns and the organisations involved in dealing with those concerns

2.2 Professional misconduct occurring during consultations between Peter Green and several patients, under the guise of the *back project*, led to the criminal conviction of Peter Green.

Pinfold Gate practice

Back project

2.3 In 1989 Peter Green developed a proposal to undertake a *back project*. He reported to his partners that he had received two year funding from the University of Loughborough.

2.4 Peter Green had informed his partners that local research ethics committee¹ (LREC) approval for the *back project* had been given but he offered no further evidence, nor did the partners seek it. Apart from a record in the minutes of a practice meeting on 19 September 1990 that a copy of the approval was available from the practice manager, no evidence to support his claim has come to our attention.

2.5 There was a belief within the partnership that other research undertaken by Peter Green had been appropriate, for example research published previously in peer referenced journals. This may have led partners to be less probing than they might otherwise have been. The belief may also have been reinforced by Peter Green's style, which was described as imposing, articulate and authoritative. He had also led the early development of GP fund holding and was well respected in the local NHS.

2.6 There are several references to the *back project* in the practice minutes which partners were led to believe, by Peter Green, was being undertaken at the university, and with the university's knowledge and approval.

¹ HSG(91)5 Establishment of Local Research Ethics Committees.

2.7 Peter Green was a lecturer teaching postgraduate students first aid as part of their certificate in education. The aim of the project was described orally to the then head of department as an assessment of the 'alignment of backs' (presumably the spinal cord) of young sportsmen in order to try and predict those who might have back problems in later life. It was understood the study would involve a small group of students. While there was no formal proposal to the university, the proposed study was discussed with university colleagues prior to the head of department agreeing to the request. This was not formally agreed in writing. Although the proposal was not linked to Peter Green's NHS list of patients it subsequently emerged that NHS patients had been involved in the *back project*.

2.8 In reviewing papers available to CHI, we noted that:

- i. on 10 February 1993, when Peter Green indicated the project was almost complete, he also reported that i) some filming of consultations had occurred with the consent of patients, mainly at the university, and ii) that drug therapy had only been used for one patient in the surgery
- ii. the drug therapy referred to by Peter Green involved the use of Midazolam (trade name Hypnovel), a sedating drug² and associated with loss of memory
- iii. its use is not uncommon in accident and emergency departments, to produce light sedation for unpleasant procedures, and is helpful in this context because it can result in amnesia so that patients are unlikely to have unpleasant memories of the procedure
- iv. in general practice, the use of Midazolam is less common, but is appropriate for procedures such as vasectomies that Peter Green and another practice partner were routinely undertaking at that time
- v. the manufacturers³ recommend that when administering the drug a second person (a clinician) should be present in the vicinity and that resuscitation facilities should be available
- vi. by the summer of 1996 Peter Green advised partners that the *back project* consultations had ceased
- vii. at about this time one of the partners retrieved a video from a broken video camera in which a semi naked man is standing with Peter Green's voice talking about body image

2.9 On 13 November 1996 the partners explored the nature of the consultations attributed to the *back project* in more detail with Peter Green, in particular the use of a relaxation technique, involving the use of a sedative injection. He explained that the technique was diagnostic, not therapeutic, and required the patient to be naked. He indicated that the relaxation technique had been used previously on 20 patients and had involved the use of a sedative injection in the surgery on one occasion. He agreed

² British National Formulary

³ Roche Products Limited

not to hold sessions in which he used the relaxation technique again. The outcome of the meeting was the instigation of a *sexual conduct protocol* signed by all partners. The protocol, which recommended the use of chaperones, also included agreement that:

- all consultations would be written up, be part of the normal clinical record and not filed separately
- total undressing of patients would not be requested except in the case of child abuse allegations when associated procedures would be followed
- Midazolam and other such drugs would only be given in the treatment room with a nurse present and another partner in the building
- the use of Midazolam would be restricted to difficult vasectomy cases

2.10 We go on to consider the concerns raised by patients and the organisations involved in dealing with those concerns below. In relation to the *back project* however, we concluded that the practice partners did not feel compelled to check the validity of Peter Green's proposal or to doubt his word that he had received formal LREC approval. The acceptance appears to be on the basis of his previous record of research, his imposing personality and the respect with which many NHS colleagues regarded him. The requirements for obtaining approval for research projects are considered further in paragraphs 2.65-2.69.

Concerns raised

2.11 Prior to 1996 there were no formal requirements for GPs and other independent contractors to have written complaints procedures in place, thus the way in which concerns were dealt with at a local level was variable. There were however, formal procedures which FPCs and their successor organisations FHSAs were required to follow for primary care.

2.12 Between 1985 and 1997 there were several occasions when concern about the nature of the consultations undertaken by Peter Green was raised at the practice.

2.13 In 1985 at least one of the partners recalls a male patient expressing concern about an injection into his groin during a long consultation with Peter Green. In a full partnership meeting, Peter Green subsequently told partners that police had interviewed him about the incident, but that the consultation had taken place behind curtains in the treatment room with a practice nurse present. The practice nurse was not asked to verify this statement by any of the partners. Administrative staff also made reference to an occasion when police taped up a consulting room door and took away a waste paper bin at about this time.

2.14 On 9 June 1992 a male patient, accompanied by his employer, met one of the practice partners to express concern about a consultation with Peter Green. Although the patient felt distressed about the situation, it was proposed to the patient that he should discuss the matter with Peter Green, or with the FHSA and come back to the partner if he remained concerned. The patient subsequently visited the FHSA (see paragraph 2.28).

2.15 A further discussion ensued between the partner, a partner colleague, the practice manager and with Peter Green, who denied any improper behaviour. A note of the discussion was made in the patient's notes. Although the patient subsequently visited the FHSA, he made no formal complaint. The patient later moved to another practice.

2.16 On 31 October 1996 a health visitor attached to the practice raised a concern with her line manager at the community trust about a patient she was counselling. The concern related to five consultations between the patient and Peter Green which had occurred over a period of time, the last consultation it was alleged lasting some two hours. As the line manager was leaving the trust that day, it was agreed the health visitor should raise the matter with one of the practice partners. Although practice meeting notes (dated 13 November 1996) refer to discussion between the health visitor and the practice manager on 6 November, the health visitor's recollection is that she spoke with a practice partner on 31 October. The partner suggested that she speak with the practice partner who was responsible for dealing with complaints about the senior partner. Peter Green was the senior partner at the time.

2.17 On 8 November 1996 the health visitor raised her concern with the appropriate practice partner and was advised the complaint would be dealt with. These concerns were discussed at a meeting between practice partners on 13 November referred to earlier in paragraph 2.8. In the meantime, the health visitor also advised her new line manager of the outcome of her contact with the practice. It was agreed that the health visitor should allow the matter to progress through the complaints procedure, but that she could provide support for the patient, for example, explaining the role of the community health council (CHC) in complaints.

2.18 On 24 December 1996, Peter Green wrote to the patient enquiring why, if he felt uncomfortable with the method of consultation, he did not say anything. On 3 January 1997, the patient made a formal complaint to the practice.

2.19 On 24 January 1997, a meeting between the patient (accompanied by a representative of the CHC), the appropriate partner and the practice manager was held to discuss the complaint. At some point, Peter Green joined the meeting and questioned the patient.

2.20 On 3 February 1997, a meeting between all partners and the practice manager was held to discuss the response to the complainant. The notes of this meeting express irritation about the length of time the case had taken. Reference in the notes is also made to the *sexual conduct protocol*, which had been agreed by all partners, including Peter Green, in December 1996. The notes also record the partners "concern and dismay" over the nature of the allegations particularly in the light of previous concerns.

2.21 On 6 February 1997, the response to the complainant on behalf of the practice concluded that there was "no evidence that Dr. Green was guilty of any professional misconduct or that he had motives other than to benefit you in his treatment of you".

2.22 On 9 June 1997, the health visitor approached a practice partner and raised a second concern about the nature of the consultations with another of Peter Green's patients. It was reported that the patient was asked to remain naked, covered by a small towel, while Peter Green used 'therapy'. It was also noted that no record had been made in the patient's notes. At this point it became apparent to the partners from the information provided by the health visitor that Peter Green had broken the *sexual conduct protocol* and hence the partnership agreement.

2.23 Peter Green subsequently confronted the health visitor about the issues she had raised. Because of this, and because she remained concerned about the outcome of the earlier complaint she had raised, she felt compelled to take the matter further with her line manager. We commend her for this action. The steps which followed are discussed in paragraphs 2.35-2.45.

Conclusions

2.24 Although concerns of a similar nature were raised with the practice on more than one occasion, in relation to the professional conduct of one individual, the complaints system as it operated during this period did not facilitate the systematic collation and overview of concerns raised by patients or others. Thus, apart from the formal consideration of one written complaint, no action ensued.

2.25 Latterly, as concerns started to emerge about Peter Green's adherence to practice protocols, there remained an acceptance of his word against that of others. This was in spite of indications that the situation as presented by Peter Green was not supported by events, as they became known.

Family Health Service Authority (FHSA)

2.26 From 1991-1996 the FHSA was responsible for investigating complaints against GPs. The procedures were specific in that the FHSA could only investigate alleged breaches in terms of service⁴ and these, together with the time scales for making a complaint were rigidly applied. Guidance assumed that the FHSA would not process anonymised complaints or complaints not submitted in writing⁵.

Concerns raised

2.27 21 June 1992. An anonymous letter was sent to the chairman of the FHSA expressing concern that Peter Green was still allowed to practise despite previous police interest. Note: this letter was brought to the attention of a staff member subsequent to the visit referred to below.

2.28 On 25 June 1992, a patient visited the FHSA office, accompanied by his employer, to make a complaint about Peter Green. The visit to the FHSA followed an earlier meeting on 9 June 1992 between the patient, his employer and a partner at the Pinfold Gate practice. Following discussion with the general manager and the medical advisor at the FHSA, it was suggested to the complainant that he should speak to the practice

4 NHS (General Medical and Pharmaceutical Services) Regulations 1974 as amended and NHS (General Medical Services) Regulations 1992 as amended

5 NHS (Service Committee and Tribunals) Regulations 1992, as amended

partner, or Peter Green and if still concerned to go back to the FHSA. The patient had made a written record of his concern, but retained this. Thus a record was not kept at the FHSA.

2.29 17 On March 1993, an anonymous telephone call was made to the FHSA about Peter Green involving the use of a drug.

2.30 On 14 April 1993, an anonymous telephone call was made to the FHSA about Peter Green.

2.31 In May 1993, the medical adviser to the FHSA responded to an enquiry from a patient about the patient's consultations with Peter Green.

2.32 On 9 June 1993, a police surgeon made an enquiry of the FHSA (unspecified) but linked to a previous allegation of a sexual nature, involving the use of a sedative drug. This was followed up by several conversations between the police and the general manager of the FHSA but no action ensued either by the police or the FHSA.

Conclusions

2.33 We have previously noted that the national procedures in place during the early 1990s included no arrangement for dealing with anonymous complaints or following up informal comments and concerns. It is clear from this retrospective study that the rigid interpretation of the procedures resulted in no action being taken. While a record of concerns raised was maintained there was no overview of the six contacts with the FHSA over the 12 month period. With the benefit of hindsight these should have been connected.

Health Authority

Background

2.34 While there are no direct line management arrangements between GPs and health authorities, following the merger of FHSAs and health authorities in 1996, health authorities became accountable for improving the quality of general medical services.⁶ Health authority responsibility also includes an overview of complaints and for dealing with matters relating to the professional conduct of GPs. Thus, following the meeting between the health visitor and her trust colleagues to discuss the nature of the consultations between Peter Green and two of his patients, the health authority became involved. Several key actions were taken by the health authority, and these are listed chronologically.

Sequence of events

2.35 On 19 June 1997, the medical director of the community trust contacted the director of public health at the health authority to express concerns about the practise of Peter Green. The director of public health initiated further enquiries within the health authority.

6 Managing the new NHS, Department of Health, 1994

2.36 In early July 1997, papers recording concerns and enquiries raised by patients and the police with the FHSA in 1992 and 1993 were provided to the health authority's director of public health.

2.37 In early July 1997, the director of public health and a partner of the Pinfold Gate practice discussed concerns regarding Peter Green's professional conduct, following which the director of public health wrote to the practice advising that he would be contacting the GMC.

2.38 On 8 July 1997, the health authority was sufficiently concerned about the professional conduct of Peter Green to refer the matter to the GMC's Fitness to Practice Directorate.

2.39 On 14 July 1997, because of the partners' growing concern, a practice partner made a search of Peter Green's consulting room during his absence on leave. The practice partner was subsequently joined by another partner on a second search. Papers were found relating to 200-250 patients, including psychological interventions and *back project* consultations.

2.40 In mid July 1997, another patient advised a practice partner of concerns about a consultation with Peter Green in April 1997.

2.41 On 31 July 1997, following legal advice, Peter Green's partners dissolved the practice partnership on the basis that Peter Green had not adhered to the partnership agreement. The five remaining partners immediately formed a new partnership.

2.42 In late July/early August 1997, a partner of the Pinfold Gate practice contacted police about the partners' concerns regarding Peter Green.

2.43 In August 1997, the papers discovered in Peter Green's office on 14 July by practice partners, were collected by the GMC after previous notification to the GMC by the partnership in mid July.

2.44 On 28 August 1997, the health authority met with two of the practice partners, the police and the GMC investigator to discuss future arrangements and consider whether there was sufficient evidence for the police to undertake a criminal investigation. At the time, police indicated there was insufficient evidence to do so. They confirmed however, that they had on file allegations of indecent assault on male patients.

2.45 As the referral to the GMC was progressing slowly, and following discussion with their legal advisers, the health authority made application to the NHS tribunal to have Peter Green's name removed from the health authority's medical list by interim suspension as swiftly as possible, pending the outcome of the referral to the GMC.

Conclusions

2.46 The health authority responded swiftly to the concerns when the issues became known to it. This included the referral to the GMC, discussion with the practice

partners about Peter Green's referral to the GMC, subsequent application to the NHS tribunal and follow up with the police authorities.

The police

Background

2.47 On two occasions, in 1985 and in 1993, the police had investigated concerns raised by patients relating to the professional conduct of Peter Green.

Concerns raised

2.48 On 13 February 1985, a patient alleged indecent assault by Peter Green following an injection of a drug.

2.49 On 9 June 1993, complaint (unspecified) but linked to a previous allegation of a sexual nature involving the use of a sedative drug.

2.50 Although the police submitted files of evidence to the Crown Prosecution Service in 1985 and 1993, neither of these investigations resulted in further action. Following the interim suspension of Peter Green by the NHS tribunal on 11 March 1998 the police sought consent for disclosure of statements obtained for the NHS tribunal hearing. Access to the information enabled them to pursue an investigation. As part of the investigation, the police also examined the *back project* papers from which they were able to put together a chart. Without access to these non-patient records it would have been difficult for the police to proceed. The chart identified similarities and characteristics of the consultations between Peter Green and patients participating in the *back project*. The police used this as a means of identifying which medical records they would need access to in pursuing their investigation.

2.51 Peter Green was arrested on 30 July 1998 when he was charged with 15 counts of indecent assault. He was released on bail, and police investigations continued resulting in a second arrest on 3 December 1998 when he was charged with a further two counts of indecent assault, one of which involved a minor. The trial commenced on 2 May 2000.

2.52 With regard to their investigation, the police referred to good liaison with the health authority, the partners and the practice. However, they commented that "the NHS did not make it easy for us". Once the police were granted legal access to specific medical records, huge difficulties were encountered with different parts of the NHS. For example, fees for copies of case notes, six week waits for notes. While these difficulties can be the experience of anyone wishing legal access to such records, the delays prolonged the investigation.

2.53 The police invested considerable time and resource into the investigation. They suggested that a formal liaison process between the statutory bodies and the police would be helpful in speeding up processes, for example access to patient specific information. Such arrangements would be helpful when there are concerns about potential professional misconduct or criminal activity. The arrangements would also

help to reduce effort and cost both to the police and to the NHS, and to assist in a swift discussion of concerns with all relevant organisations.

2.54 Patients and staff talking to CHI expressed a feeling of lack of support from the police and the health authority, for example, on what to expect immediately prior to the trial. From the limited information available to us it was clear that a much more structured and supportive approach for witnesses and others directly affected is essential. Witnesses are in a vulnerable position when very personal details are in the public domain. Being a witness in these circumstances is a very isolating experience. There was a lack of clarity for some about how information they disclosed would be used in court and this caused additional anxiety.

Conclusions

2.55 Where there are concerns about the potential for professional misconduct or criminal activity, three key requirements emerged from our discussions with the police and others:

- a system to facilitate rapid discussion between the police, relevant NHS bodies and others to discuss concerns
- a quicker system of accessing patient specific records to speed up police investigations
- when patients and staff participate in such high profile and personally distressing investigations, a mechanism whereby the police and the NHS can ensure they are supported and valued by all the agencies involved

The General Medical Council

Background

2.56 Prior to August 2000, the GMC could only consider making an interim order of suspension when their preliminary proceedings committee (PPC) - the first committee stage of the GMC formal procedures - had decided that allegations against a doctor raised a question of serious professional misconduct. In these circumstances the case would be referred to the professional conduct committee (PCC) for a full inquiry.

2.57 The GMC was considering a complaint about Peter Green forwarded to them in May 1997 when the health authority referred Peter Green to the GMC on 8 July 1997. The purpose of the health authority referral was to establish what action should be taken. GMC solicitors investigated further and approached the police.

2.58 Peter Green's registration was suspended on 2 June 1998 by the GMC's PCC for an initial period of six months. The order was renewed by the PCC on 3 December 1998. Thereafter suspension was renewed at three monthly intervals until November 2000. With the introduction of new GMC powers, the interim orders committee (IOC) of the GMC determined that Peter Green's suspension should continue.

2.59 Several interviewees referred to GMC progress as “sluggish”, which they believe extended the length of time Peter Green was able to continue to practise. Indeed because of the delays, and as a secondary measure, the health authority also referred Peter Green to the NHS tribunal for interim suspension, not only from the medical list of the health authority but all other medical lists within England and Wales. Nonetheless, progress remained slow. This was because:

- the prosecution of Peter Green centred on the same allegations as those referred to the GMC, the case could not be heard by the GMC’s PCC until the outcome of criminal proceedings was known
- the number of referrals to the GMC has been increasing in recent years, for example, in 1995 the GMC received 1500 complaints, in 2000 the GMC received 4500 complaints

2.60 Because Peter Green has subsequently appealed against his criminal conviction, the GMC cannot hold a PCC until the outcome of that appeal is known. Thus Peter Green remains on suspension.

Concerns raised

2.61 The GMC had received relevant enquiries relating to Peter Green as follows:

- In April 1993, an enquiry about the legitimacy of a research project, which apparently involved the use of a muscle relaxant and taking part in sexual role-play
- In 1993, an anonymous telephone call on the same issue

2.62 The GMC also highlighted the need for establishing effective and speedy communication with other bodies, for example, the police. They acknowledged that care should be taken not to interfere with court procedures or to prejudice the outcome of a court case. An internal protocol has therefore been developed to improve communication with the police. The GMC are also involved in agreeing a wider protocol to improve communication between the police, the NHS and the teaching regulatory bodies. This is essential to ensure an appropriate balance between maintaining confidentiality and protecting the patient. The GMC also referred to delays in accessing patient records.

Conclusions

2.63 While the investigation by the GMC took almost ten months to reach a conclusion, this should be viewed in the context of an increasing number of referrals to the GMC and during a period when the GMC is actively reforming its structures and processes.

Managing the issues arising out of the *back project*

2.64 In this section we consider the impact on patients following Peter Green's referral to the GMC and subsequent conviction, and the way in which the health authority managed the impact.

Research in the NHS

2.65 There has been a health authority wide local research ethics committee (LREC) in Leicestershire since 1978. Health service guidelines, which all health authorities are required to operate, require that all those working in the NHS, including those in general medical services, must seek research ethics committee approval for research projects. NHS organisations also have to approve projects, in the light of LREC views.

2.66 There is no legislation relating expressly to LRECs, nor a legal requirement for research to be referred to them. In practice however, it is the norm because:

- NHS bodies require it under Department of Health guidelines
- health authorities and trusts make it an administrative requirement
- most professional journals require ethical approval of research

2.67 Within the system there is no means of identifying individual clinicians who may be engaging in unapproved research projects. Reporting arrangements are such that the health authority would not be in a position to monitor individual research projects. Unless concerns are raised with the health authority directly, there is no mechanism to deal with those concerns. Additionally, GPs, and indeed other professionals, are under no obligation to advise the health authority of research being undertaken outside of NHS services for which they are contracted.

2.68 A *Research Governance Framework for Health and Social Care* has recently been introduced and applies to all those working in the NHS involved in health and social care research, and those working with the NHS on research, for example, universities and industry.

2.69 Within the framework health authorities and trusts (including primary care trusts) are required by the Department of Health to ensure that there is a:

- system in place so that the organisation is notified of all research being undertaken relating to NHS patients
- named person responsible for ensuring that informed consent and other procedures within agreed research protocols are adhered to

We welcome the new framework, which provides very clear standards for the NHS. The framework however is not laid down in statute. Thus the standards are guidance for good practice. While as a result of revised arrangements it is unlikely NHS research would go undetected without LREC approval, practitioners remain under no obligation to inform the health authority or trust of research activity undertaken outside of the NHS.

Managing the impact of the *back project*

2.70 When the issues relating to Peter Green emerged, the health authority was responsible for managing the impact on local services. There were several issues, which concerned people talking to CHI:

- Peter Green continuing to practice until his suspension on 11 March 1998
- The help line established by the health authority to advise people during the trial of Peter Green
- The assignment of patients registered with Peter Green to other GPs in the area following his conviction

Peter Green continuing to practise at the Pinfold Gate health centre

2.71 Initially the full reasons behind the partnership split were not clear to many people. For example, practice staff thought that the reasons were financial. Although practice staff had met with the partners they were not told the reasons for the split. Some, as long standing employees, felt that they should have been told. While with hindsight practice staff appreciated that the partners were trying to protect them from the media and other enquiries, at the time it felt as though they were not trusted. The outcome was speculation and rumour. This was compounded by the new arrangements whereby Peter Green continued to work at the health centre. Staff found this very difficult, for example, meeting requests from Peter Green for services such as typing and photocopying.

2.72 As details of the events emerged, practice staff and others talking to us were surprised, not only that Peter Green was allowed to continue to practise but also to continue to practise in the same building and in a room on his own. They felt these actions legitimised Peter Green's alleged behaviour.

2.73 However, following a practice split, it is not unusual for a GP to occupy the same building as former partners. Indeed this had happened elsewhere in the health authority area. The health authority was contractually required to approve the base from which Peter Green could practise as they had been unsuccessful in persuading him to refrain from doing so. As the issues became apparent, and their handling gained momentum, it became clear that matters would take some time to resolve. Thus, a priority for the health authority was to progress suspension through the NHS tribunal or the GMC. While the health authority accepted that the arrangements put in place might not appear to acknowledge the seriousness of the situation, its view was that providing accommodation within the confines of an established health centre was preferable to Peter Green operating in complete isolation in premises elsewhere.

The help line to advise patients and the public during the trial of Peter Green

2.74 An enquiry line (referred to as a help line in press statements) was established by the health authority for the period of the trial of Peter Green and subsequently. At the

time of the investigation, the health authority was still receiving enquiries. The purpose of the help line was to direct people to the appropriate service for their needs, for example counselling. The line was open during office hours although for the week following the conviction of Peter Green, it was open until 7.00 pm. An initial attempt was made to seek advice on establishing and running a help line but this was not followed through. As part of the handling arrangements an agreement was reached between the relevant agencies about which enquiries, with the permission of the caller, should be referred to the police or to social services. It does not appear however that a formal protocol was established to cover specific issues, for example, confidentiality.

2.75 The calls were dealt with in house by health authority staff, mainly through one health authority officer with some support and advice from a public health doctor and an administrator. No specific training was provided for those dealing with the calls, which made greater demands on the help line than had been anticipated.

2.76 The availability of the service had been widely publicised locally, but the national press had not picked up the issue in their coverage. Some stakeholders believed that coverage of the help line should have been targeted nationally, as some of those directly affected by the events had moved away from the area.

2.77 People talking to us, both NHS staff and the public, were unclear about the purpose of the help line and felt there was a lack of sensitivity to the issues. For example:

- the difficulty for people who might wish to seek confidential help and advice on intensely personal issues, having to do so through staff at the health authority, who may have been involved in dealing with a previous concern or complaint
- being offered counselling through services provided by local general practice; a lack of clarity about the employment status of the counsellors and their connections with the practice concerned, and indirectly to Peter Green
- staff directed to advice and/or support through their local community trust, that is professional colleagues with whom they may deal on a day-to-day basis
- the difficulties for people disclosing personal information, for example name and telephone number on an answer telephone when they were unclear who would have access to that information
- a small number of people felt that help line staff had appeared dismissive of their individual circumstances.

Assignment of patients registered with Peter Green

2.78 When the practice partnership was dissolved, the health authority had a contractual duty to ensure that patients registered with Peter Green were informed of the practice split and that Peter Green would continue to practise as a single handed practitioner. Accommodation was provided within Pinfold Gate health centre.

2.79 CHI heard that these new arrangements created confusion for both practice staff and for the patients. The reasons for this were:

- many patients registered with Peter Green may never have consulted him during the period of their registration with the practice, their preference being to consult with other partners, an arrangement they would have preferred to continue, rather than being transferred to a different practice
- the practice would not have seen the letter to patients advising of the new arrangements and would not immediately be aware which patients were directly affected by the changes

2.80 A strongly held view amongst practice staff and the local medical committee was that the health authority should have provided locum cover so that the disruption to patients could be minimised, and assignment of patients planned and co-ordinated over a period of time.

2.81 Arrangements were made with a neighbouring practice to provide locum cover, which continued for three weeks. This proved impractical and as a result on 2 April 1998 the health authority interviewed for a locum doctor to care for Peter Green's registered patients. The candidate subsequently withdrew. Thus in consultation with local GPs, patients were assigned by the health authority to other GPs in the area. Letters advised patients that they would be assigned to a different GP on a temporary basis following Peter Green's suspension in March 1998, arrangements which were formalised in July 2000 when Peter Green was convicted. There was considerable anxiety about this. For example:

- although the health authority had circulated letters and explained the new arrangements, patients would turn up at the health centre not realising they had been assigned to another practice
- practice staff were unable to assist with immediate enquiries and concerns because they did not know to which GP patients had been assigned
- we heard from one interviewee that some families were split and assigned to different practices in the process
- some patients felt they should have been offered choices

Conclusions

2.82 Although the reason for the partners not communicating the full reasons for the partnership split to practice staff was for the best of intentions, many staff felt they should have been told. Uncertainty was created by a lack of information for those in direct contact with patients. It was compounded by the difficulties for the health authority in ensuring consistent communication in such a high profile situation when there was no common understanding of the full events, at the onset. Nonetheless, we concluded that more focused attention on communicating the issues within the community and with practice staff would have reduced speculation and anxiety.

2.83 While the actions taken by the health authority in allocating Peter Green accommodation in the Pinfold Gate health centre may have appeared to legitimise his behaviour, in the absence of a conviction for criminal activity, the health authority was unable to remove his name from its medical list without reference to the GMC or

NHS tribunal. In these circumstances the health authority action in ensuring accommodation for Peter Green was appropriate.

2.84 The health authority had clearly recognised the need for a help line and given thought to the planning, publicity and running of the service. Apart from an initial attempt however, no further endeavours were made to seek advice from others in the NHS with relevant experience. The help line would have been enhanced if those dealing with the enquiries had been allocated to work solely on that service, possessed the appropriate counselling skills and had not previously been involved in related issues. At the very least such expertise should have been available during the period of the trial and inevitable media intensity.

2.85 In the circumstances, we concluded that the re-assignment of patients by the health authority was not well communicated to practice staff and to patients. This was particularly relevant given the high profile events, which necessitated the changes in registration.

Discussion

2.86 Several people talking to CHI commented that they had no prior knowledge about the events leading to Peter Green's conviction. However, patients and members of the public found it incomprehensible that only the police knew of the concerns. A number of NHS staff we interviewed also inferred that at the time, because the police did not prosecute, there was no cause for concern.

2.87 In reviewing the issues, we noted that between February 1985 and January 1997 there were twenty three occasions when an individual or organisation was aware of a concern or complaint involving Peter Green. These were people working at the FHSA, doctors and staff in the Pinfold Gate practice, staff in the community trust, officer(s) at the GMC, and the police. As the investigation progressed CHI, and those talking to CHI, started to refer to these incidents as 'pieces of the jigsaw'.

2.88 The matrix in *Table 1* identifies the 'pieces of the jigsaw'. They are represented as single occasions when an issue relating to Peter Green was raised. Each of the occasions has been annotated as a means of identifying those which evidence suggests are related to a single event. For example, those occasions annotated as (a) probably relate to one complaint or concern.

2.89 Some interviewees referred to 'collective memories', that is, individuals within an organisation having a memory of events that can be linked, and a system for recording those events which can be sustained over a period of personnel and organisation at change to enable the retention of 'intelligence' by people managing and delivering the service. When viewed collectively the 'pieces of the jigsaw' highlight graphically the absence of any co-ordination to enable such an overview or to trigger warnings, and the weakness of a system that considers formal complaints only. The 'pieces of the jigsaw' also suggest that there was a 'collective memory' within the practice, but it was not triggered, that is, partners who had concerns, discussed them, drew up a policy, but did not put the whole picture together.

7 Guidance on the implementation of the NHS Complaints Procedure, NHS Executive, March 1996

Table 1 Pieces of the jigsaw. Occasions when concerns about Peter Green and consultations with some of his patients were discussed between February 1985 and January 1997

Year	FHSA	Practice	Community Trust	Police	GMC
1985		i) Partner(s) recall male patient expressing concern over injection (a) ii) Staff aware of police taping up consulting room door (a) iii) Peter Green advises partner that he has been interviewed by police (a)		13.2.85. Patient alleges indecent assault (a)	
1992	21.6.92 Anonymous letter to FHSA 25.6.92 Patient visits FHSA office (b)	9.6.92. Patient discusses concern with practice partner (b) 6.92. Discussion between practice partner, partner colleague, practice manager and Peter Green (b)			
1993	17.3.93 Anonymous telephone call to FHSA 14.4.93 Anonymous call to FHSA 5.5.93 Medical adviser responds to enquiry from a patient about Peter Green 9.6.93 Police enquire about use of sedative drug (c)			9.6.93 Complaint about the use of a sedative drug (c)	April Enquiry regarding Peter Green's research project. [No date] Anonymous telephone call regarding Peter Green's research project.
1996		Summer 1996. Partner retrieves video from broken video camera in which a semi naked man is standing with Peter Green's voice talking about body image. 31.10.96 Health visitor raise concern with practice (d) 8.11.96 Health visitor discusses patient concerns about Peter Green consultations with practice partner.(d) 11.11.96 Meeting between practice partner, practice manager and Peter Green.(d) 13.11.96 Discussion between partners at practice meeting (d) 24.1.97 Meeting between patient, CHC, practice partner, practice manager and Peter Green (d)	31.10.96. Health visitor discusses concerns with line manager (d) [No dates] Discussion between health visitor and new line manager regarding concerns (d).		

2.90 At the heart of the matter lay an NHS culture that did not listen to, or treat complaints inquisitively. This left patients powerless in the face of clinicians and managers. While the complaints process in the 1980s and early 1990s was not effective by current standards, none of what has been alleged, or the responses to those allegations until the conviction of Peter Green, can be condoned. Listening to NHS staff and patients as they described the way in which individual events were dealt with, the overriding impression is one of the potential for *a credible person doing incredible things to patients to whom he had a duty of care*.

2.91 Even when the focus of complaints handling changed, when new procedures were introduced in 1996⁷, the acceptance of the facts still relied on a health visitor, not employed by the practice, raising concerns as a professional and as an advocate for the patient. It was her concern and persistence that acted as a catalyst and triggered action, leading to the referral of Peter Green to the GMC. We noted that in other such high profile cases the whistle blower has been someone working outside of the immediate organisation, as was the case on this occasion.

2.92 It is also evident that one of the purposes for which local research ethics committees were established, that is to protect the interests of patients participating in research projects, have no value should a professional choose not to follow agreed procedures. There are no statutory mechanisms either for compelling individuals to make application to the LREC, or for auditing whether application has been made.

2.93 The public perception of events surrounding Peter Green was at variance from the facts of the case. Much of this may have been due to a lack of an accurate and common understanding of the issues amongst those in the local NHS at the onset. Clearly, effective and sensitive co-ordination of internal and external communication during periods of intense media and public scrutiny such as that arising out of the suspension and conviction of Peter Green, have a particular significance in maintaining public confidence in the NHS. We refer to this further in chapter 5.

3 | Could the abuse have been prevented?

3.1 In this Chapter we consider accountability and management arrangements in place between 1977–1998 as they relate to primary care and to:

- the role of the Trent regional office in performance managing the provision of services within the Leicestershire Health Authority area
- the role of the Leicestershire Health Authority in monitoring and improving the quality of general practitioner services and monitoring and improving the quality of patient care provided by GPs
- the role of GPs practising in partnership with Peter Green in ensuring appropriate policies and procedures to safeguard the interests of patients.

3.2 We then go on to consider the referral systems available to the health authority where there are causes for concern about clinical practice or professional conduct.

The role of the Trent regional office

Background

3.3 Regional offices were established in England in April 1996¹. Their purpose is to streamline NHS performance management arrangements across hospital and community health services and general medical services. Regional offices were preceded by regional health authorities (RHAs) whose responsibilities included the appointment of FHSA members, allocating funds to FHSAs, monitoring FHSA plans and ensuring they were co-ordinated with those of health authorities. Current regional office responsibilities include:

- ensuring the implementation, communication and co-ordination of national policy with the NHS and others working with the NHS
- managing the performance of the NHS in their region and setting the strategic framework within which local discretion is encouraged

Clinical governance

3.4 Structured performance management arrangements are in place region wide to monitor the development of clinical governance in primary care through the health authority. These arrangements comprise:

¹ HSG(94)22 and HSG(94)53. Regional Health Authorities/Regional Offices. Guidance notes on divisions and functions.

- patch teams responsible for a group of trusts and health authorities. The team comprises a performance manager with nursing and public health staff support
- whole system mid year review, which includes primary care group chairs looking at the system of clinical governance within the health authority area
- public health visits to each health community to discuss clinical governance with medical staff and medical input into the local discussions

Untoward incident reporting

3.5 There is a regional clinical governance reference group chaired by the regional director of public health. As a sub committee of the executive board, the group co-ordinates and monitors untoward incidents. Arrangements include action plans, which involve the communications team and performance managers. Patch teams receive information relating to untoward incidents region wide and have the opportunity to feed into the discussion.

3.6 Historically there has been no back tracking of incidents, and the regional office welcomed the proposals from the chief medical officer to facilitate systematic recording of all critical incidents.

3.7 With regard to complaints, as with health authorities, regional offices (and previously RHAs) receive only minimal information. Within current arrangements there are no mechanisms through which effective monitoring of complaints in primary care can be undertaken.

Issues relating to Peter Green

3.8 In relation to Peter Green, regional officers saw their role as ensuring the health authority dealt with issues appropriately and as locally as possible. It had been a difficult situation for the health authority to manage, there was intense media attention, a police investigation and the re-assignment of patients to consider. Regional officers also shared the health authority's sense of frustration about the inability to do something immediately, for example, suspending Peter Green. Their purpose throughout was to provide expertise and advice where this was appropriate, for example, about communication issues. Nonetheless, in their view the health authority had dealt with the issues promptly and appropriately.

3.9 With regard to convening the health authority's reference committee, having taken advice from the centre, regional officers had asked the health authority to proceed as they believed there was evidence from the chronology of events that there was knowledge about Peter Green's conduct within the practice.

3.10 Where there is serious concern about a hospital or community medical practitioner, NHS guidance advises on the circumstances where regional director of public health (RDPH) can issue an *Alert Letter* to the NHS in the interests of public safety. Although the guidance does not cover primary care practitioners, the RDPH took advice from the NHS Executive headquarters about the need to issue an *Alert Letter* regarding Peter Green. The RDPH was advised that if she felt public safety issues

warranted it, she should do so. On this basis, an alert was issued by the RDPH to all directors of public health in the region asking them to circulate the information to GPs on their list. The RDPH also sent copies to her RDPH colleagues inviting them to consider doing the same.

3.11 Leicestershire Health Authority did not issue the *Alert Letter* to their GPs. This decision was based on the authority's own legal advice that the guidance referred to above was not intended to cover primary care and could have been considered to be prejudicial at that time.

Conclusions

3.12 Within current performance management arrangements the regional office have developed mechanisms, which enable them to monitor the implementation of clinical governance and to co-ordinate untoward incidents as they occur within the region. The process facilitates learning across patch teams.

3.13 The right balance between performance management and appropriate delegation when there are high profile issues of public concern is a difficult one to achieve. Nonetheless, we concluded that the regional office had given appropriate support to the health authority through a period of intense media and public scrutiny. Clearly the instruction to convene the reference committee resulted in considerable anxiety for those practitioners directly affected by the outcome, and pressure on the health authority to act. Overall, however the approach adopted by the regional office throughout the period leading up to, and during, Peter Green's trial, was felt by the health authority to be supportive.

The role of Leicestershire Health authority

Organisation and management

3.14 As we have reported, throughout the 1970s and 1980s GPs had no direct accountability either to FPCs, or through the FPC, to others in the NHS. There was no formal mechanism by which the quality of general medical services could be monitored, other than through complaints. The complaints system during this period, which was essentially fact finding into alleged breaches in terms of service, did not consider specifically quality of care and clinical issues.

3.15 People talking to CHI, who had been employees of Leicestershire FPC, confirmed the highly administrative nature of the systems to support general medical services, which were adhered to prescriptively as laid down in the regulations². The concept of performance management in terms of managing and monitoring the quality of general medical services was not introduced until the establishment of FHSAs and the new GP contract, both of which came into force in April 1991³. Even so, the view of several interviewees was that developing managerial relationships in the early 1990s was based

² NHS (General Medical and Pharmaceutical Services) Regulations 1974 as amended and NHS (General Medical Services) Regulations 1992 as amended

³ NHS and Community Care Act, 1990

very much on what could be agreed between the FHSA and general practice, as there was a resistance to arrangements that might threaten independent contractor status.

Working relationships between the FHSA and the health authority

3.16 Views expressed to CHI epitomised the cultural differences that were characteristic of the FHSA and the health authority in the early stages of developing working relationships. For example:

- those without a working knowledge of the FPC and its successor organisation, the FHSA, were surprised by what they perceived to be the administrative nature of the FHSA and the culture of protecting the professional interest, which had been a feature of the FPC and was still evident in the early 1990s
- health authority staff previously involved in hospital and community health services and the principles of performance management, which had evolved during the 1980s to include clinicians, felt constrained within the context of performance management by the unique effect of independent contractor status
- others with experience of working in, or with general medical services, felt that the health authority was too acute care focused and did not properly understand primary care issues

In our view, these perceptions would have been widely held in the NHS in the early 1990s. Such perceptions are hardly surprising since for over forty years hospital and community health services and general medical services had been managed and administered separately, and training for general managers in the NHS had been focused on hospital and community health services. Thus in the early 1990s some working relationships at the FHSA were acknowledged to be challenging.

Developing and monitoring general medical services

3.17 In addition to the statutory requirement to develop clinical audit through medical audit advisory groups (MAAGs) CHI heard about:

- development of a voluntary contract with primary care to encourage practices to audit their work
- the introduction of the blueprint (see glossary of terms process) in the mid 1990s to audit practice organisation in primary care and which gained Kings Fund accreditation. Latterly a reciprocal Leicestershire/Sheffield accreditation process has been taken forward to primary care groups and referred to further in chapter 4
- health authority service specifications outlining the responsibility of the community trust for leading the training programme for GPs wishing to undertake the child health surveillance programme

3.18 We also noted a strong commitment to develop and maintain good working relationships between the local medical committee and FHSA, and subsequently the health authority. Specific examples include:

- working together to develop practice staff training budgets, a scheme which is still in operation

- the establishment of one of the first accredited countywide occupational health schemes
- the local medical committee acting as a sounding board for, and advising the health authority on, the implementation of policy, for example, chaperoning, intimate examinations

Improving the quality of patient care

3.19 Initiatives to improve the quality of care for patients included the early development of locality planning and commissioning, with a director linked to each locality and joint (FHSA and health authority) health needs assessment at practice level to include an assessment of the needs of children and young people undertaken by health visitors.

3.20 The arrangements were underpinned by a strategy group for primary care which involved representatives from the local medical committee, the community trust and both service and academic GPs to consider a number of quality issues, for example, the development of co-operatives for out of hours, the introduction of serious untoward incident reporting arrangements.

Monitoring the quality of patient care

3.21 Until 1990, apart from the availability of limited information arising out of complaints, monitoring was mainly through financial and activity information held by FPCs, for example frequency of night visits, levels of prescribing.

3.22 A review of board papers (between 1990 and 1998) highlighted the way in which the FHSA board, and subsequently the health authority board had developed monitoring of general medical services across Leicestershire. These included:

- quarterly reports on complaints monitoring to the FHSA board, for example, in August 1993 the board considered a paper detailing the outcome of complaints as a means of learning from complaints and improving the quality of service
- a non executive director of the board nominated with a responsibility for complaints issues
- service specifications for children's services
- performance monitoring including patient charter issues and financial activity

Child protection issues

3.23 Partnership arrangements with local authorities in relation to child protection are well developed. CHI heard that the area child protection committee (ACPC) was well established, despite local government re-organisation, and was felt to be a credit to all organisations involved. A senior health authority manager attends all meetings. This reinforced the view of the health authority's commitment to this issue. In addition to health, the committee also includes representatives from probation services, the police, education and social services.

3.24 CHI also noted the routine quality visits to review progress on implementing policy guidance in relation to child protection. The health authority's designated child protection officers undertake these⁴. More recently a sub group of the ACPC has been tasked with looking at the development of a quality assurance framework for child protection to which all agencies involved will work.

Conclusions

3.25 Clearly at a national level there was an expectation that FHSAs and their successor organisations, health authorities, would provide a framework to improve the quality of general medical services. Many interviewees described early concerns about the difficulty of achieving this in the context of the cultural differences that existed in the early 1990s. Nonetheless, we found evidence to support the view that at an early stage the FHSA and subsequently, the health authority, had worked to overcome these difficulties. There was also evidence of a commitment to work with the local medical committee, which was reciprocated.

3.26 We concluded that while working under separate statutory arrangements the FHSA and the health authority had worked constructively to plan for and develop joint working arrangements ahead of the formal merger in 1996, for example, early development of locality commissioning. We discuss evolving arrangements for improving the quality of care further in chapter 4.

3.27 Child protection is a key issue for the health authority evidenced by their regular participation in the ACPC and the ongoing routine quality visits undertaken by the health authority's designated child protection officers.

Complaints handling at authority level

Background

3.28 The process for dealing with and responding to NHS complaints has changed dramatically in the last two decades. The most significant change was in 1996 when new procedures were expanded to include all those working in the NHS. A key aim of the new procedures was to learn from complaints. A clear separation between complaints handling and disciplinary procedures was also made. While there is a requirement for complaints procedures to be in place within general practice these are not regulated by the health authority, nor is there a statutory mechanism for the health authority to monitor the effectiveness of those procedures within general practice.

Complaints policy and implementation

3.29 From their scrutiny of board papers CHI noted that FHSA reporting to the board comprised quarterly reports providing an analysis of the number of complaints received. Reports also reflected discussion about how the FHSA could improve the way in which they managed the processes and included regular evaluation of all stages of the procedures in place at that time.

⁴ Working together to safeguard children. Department of Health. December 1999

3.30 With the introduction of new procedures in 1996, the board considered a revised policy in July 1996 although there have been regular updates since that time. Subsequently the board has received reports on an annual basis.

Complaints handling

3.31 CHI reviewed a random selection of complaint files: 1992/93 (FHSA), 1996/97 (when the new NHS complaints procedure was introduced) and 1999/00. The files related to all complaints received by the health authority, not just those relating to primary care, since they are not filed separately. An analysis of this review is included in appendix G.

3.32 Three areas of concern were highlighted by the review:

- no evidence of a mechanism to follow up action taken as a result of complaints, either by the patient or the practice, making it difficult to determine how lessons from complaints could be learned
- some evidence of inconsistency in the information given to complainants, for example, information on how to proceed if the patient remained dissatisfied following local resolution was not always given
- not all letters referred to the role of the lay conciliator, which is unfortunate since the CHC confirmed the facility worked well and was available health authority wide

Conclusions

3.33 Overall we concluded that the formal complaints process was handled well both by the FHSA as laid down in the regulations, and subsequently by the health authority. However we found no evidence of a mechanism to follow up action taken as a result of complaints. From the review it was not possible to assess the effectiveness of handling informal concerns and local resolution issues, as there are no mechanisms that enable health authorities to do this.

The role of the practice partners

3.34 In this section we review the organisation and management arrangements within the Pinfold Gate practice, and the practice based complaints procedure. Policy issues such as chaperoning are discussed in chapter 4.

Background

3.35 The partnership, of which Peter Green was a member, was established in July 1948, and until 1969 comprised six partners. Peter Green had been a partner since 1977. By 1973 there were six partners, which was the case until July 1997 when the partnership was dissolved. A new partnership comprising the five remaining partners was established immediately. Throughout its history, the partnership has remained fairly stable; indeed between June 1988 and July 1997 there were no partnership changes at all. The partnership has operated from the Pinfold Gate health centre in Loughborough for 18 years.

3.36 Many NHS staff talking to CHI regarded the practice as better than average, for example, the early development of a protocol for cervical screening. Some partners are involved in GP training - one is a course organiser, another an approved trainer. The practice is involved in medical undergraduate training. Pinfold Gate was one of the first practices in the area to employ a practice manager, and despite the recent difficulties practice staff felt a considerable loyalty to the practice as a whole, and a pride in the service they provided. Many patients responding to the CHI survey of patients registered with Peter Green also expressed satisfaction with the service provided by the practice, and by Peter Green.

Organisation and management

Partnership agreement

3.37 There has been a written partnership agreement within the practice in line with general practitioner committee guidelines for many years. This is amended when partnership changes take place and provides the legal framework within which the practice operates. The agreement requires research projects to be approved by all partners, which are discussed and recorded at practice meetings.

Roles and responsibilities of the partners

3.38 Partners have organised themselves to take specific executive roles on behalf of the practice, for example, prescribing issues, health and safety, finance. In the 1980s and early 1990s the responsibilities were simply allocated but in the last decade the process has evolved so that responsibilities are allocated to people with a special interest or specific skill. Partners felt that this worked well.

Meetings at practice level

3.39 At the time of the investigation the practice had arrangements in place for regular meetings of practice staff. These included:

- weekly Wednesday morning meeting between the partners (45 minutes) to discuss routine matters, for example, patient registration, stock levels, etc., and for which minutes are kept

- Thursday lunchtime meetings of the partners, and other professional staff, including attached staff. These meetings provide opportunities to discuss clinical issues, for example, guidelines, but no minutes are kept
- quarterly business meetings which focus on financial, workload and planning matters and for which minutes are kept

The practice manager now attends all of these. This a more recent arrangement.

3.40 Other practice staff have the opportunity to meet to share ideas and concerns. These meetings are chaired by the practice manager who acts as the link between partners' meetings, which she attends representing the rest of the staff. A partner will attend a practice staff meeting if there is a specific issue, which requires GP attendance, but this is not a regular arrangement. There are occasional full practice meetings but these are not scheduled on a regular basis.

Appointment systems

3.41 We heard on several occasions that patients attended the Pinfold Gate health centre to see Peter Green without an appointment. These arrangements were outside of the normal practice procedure. Practice staff confirmed that this was so. This was evidenced by:

- consultations by Peter Green at the practice which ran into Saturday afternoons, and when the single receptionist on duty in the morning had left the surgery
- patients not registered with the practice, but arriving for appointments booked by Peter Green, but not recorded on the practice appointment system
- recording of appointments on the appointments system retrospectively by administrative staff being removed by Peter Green

3.42 Practice staff believed that Peter Green's working practice was common knowledge amongst the partners and others working with the practice. Many staff did not feel able to discuss these concerns. Staff also referred to Peter Green as an imposing figure with an authoritative manner. He was a long standing and well respected partner and with a few exceptions, practice staff felt unable to question or challenge his practice.

Drug administration

3.43 All fully registered doctors may write prescriptions and obtain drugs. It is difficult to monitor this activity, particularly when prescriptions are issued privately.

3.44 One area of concern was the alleged use of Midazolam in the course of the *back project*. Midazolam is controlled under the *Misuse of Drugs Regulations*. However, like most benzodiazapines, it falls within Schedule 4, Part II of the regulations where there are no requirements for safe custody, record keeping, retention of invoices or specific prescription requirements.

3.45 At the Pinfold Gate health centre one of the partners is responsible for prescribing issues and in 1997 had undertaken a review of the practice prescribing data. No unusual trends had been identified. Midazolam was purchased privately in connection with the vasectomy work undertaken by two of the partners, one of whom was Peter Green, but practice colleagues would not necessarily be aware of drugs purchased privately.

3.46 Several interviewees felt that drugs such as Midazolam should be made subject to stricter controls, for example, by moving the drug from Schedule 4 Part II to Schedule 2 or 3 of the Misuse of Drugs Regulations 1985.

3.47 In relation to Schedule 2 controlled drugs, doctors are required to keep a bound register of all such drugs supplied and obtained. Registers are subject to scrutiny by Home Office Drugs Branch Inspectors. Schedule 2 controlled drugs must be stored in a locked cabinet and are also subject to strict rules in relation to their destruction.

3.48 A new system of recording controlled drugs has been implemented at the practice by the practice manager and is within national guidelines. However, it would be more appropriate to use a bound book, rather than loose pre-formatted sheets, which were in use by the practice at the time of the CHI visit.

3.49 We also noted during our visit that all controlled drugs were kept in a locked cupboard in a non-clinical room. The keys were locked in the practice manager's safe. The key for the safe is held by her. There was a spare key that appeared to be randomly stored should doctors need to access the drugs during the practice manager's absence.

Training and development

3.50 Throughout the discussions with practice administrative staff there was a lack of clarity about training for staff. Much of the training appeared to be undertaken on an ad hoc basis, there being no agreed programme for staff. There is discussion about policies and procedures at staff meetings and some awareness training, for example, on complaints which has been provided through the health authority. Nonetheless, administrative staff expressed a wish for additional training in areas such as information technology, health and safety, the role of primary care groups and primary care trusts.

3.51 We heard that the practice manager was proposing to introduce an appraisal system for practice staff, which would also identify training and development needs. This was welcomed but more detailed discussion with the primary care group is required to develop an ongoing agreed programme of training.

Conclusions

3.52 Although not uncommon, in our view the arrangements for practice meetings, as described to us, are not conducive to good quality communication between the full primary care team, that is, between medical, nursing, administrative and other clinical staff. These arrangements may also compound the difficulties expressed by some about raising areas of concern, for example the appointment system.

3.53 Our findings in relation to the appointment system are a matter of concern and merit review to ensure the system is now used and managed appropriately. Practice staff also need to be assured that when irregularities occur, for example, patients arriving without an appointment to see Peter Green, they can be certain their concerns will be listened to and appropriate action taken.

3.54 We concluded that within the health authority area all drugs (for both private and NHS use) purchased for general practice should be the responsibility of a single individual within each practice, and a counter signatory to ensure probity. The introduction of audit trails, such as those developed in the acute sector within the controls assurance standard on medicine management, would be timely. We refer to Midazolam and the issue of it being the subject of stricter controls in chapter 5.

3.55 With regard to staff training, we noted the commitment from the practice manager to introduce appraisal systems for practice staff. Nonetheless, we conclude that there is an urgent need for the primary care group to review with each practice in their area the training needs of all staff (including attached staff) in the light of the events, which triggered the CHI investigation.

Practice based complaints procedure

Policy

3.56 We received conflicting messages about a complaints policy at practice level prior to the introduction of the new complaints procedure in 1996. Some partners and staff believed that there was a policy in place prior to 1996 but were unclear about the detail. Some were aware that the first point of contact was the practice manager and that the senior partner dealt with complaints unless the subject of the complaint. We received no evidence of a written complaints procedure prior to 1996. Indeed, prior to 1996 there was no requirement for a practice based complaints procedure. From the information available to us, it appeared that the practice was following the procedure in use at the FHSA.

Complaints handling

3.57 We found very little evidence of recording complaints within the practice prior to 1996. The team noted that subsequently, between 1996 and 1998, there was evidence of a formal procedure. However the complaints file reviewed for that period revealed a varying standard of recording and handling the issues. Since 1998 the system appears much improved, the files being easy to identify and filed in chronological order. In a random check of three recent complaints it appeared that every effort had been made to achieve early resolution. The correspondence was clear and informative and patients were given clear options should they be unhappy with the outcome.

3.58 One area of concern however was that the sheets completed for the North Charnwood Primary Care Group as part of the recently introduced complaints monitoring system, included the patient's name. This is inappropriate. More appropriately the sheets should provide a mechanism for coding individual

practitioners, or groups of practitioners, in order to monitor trends and identify points of potential or consistent areas of concern. This is essential to improve quality and change clinical practice where this is identified to be necessary.

Conclusions

3.59 From our review of complaint files we noted that the system had been much improved following the appointment of the new practice manager. The format of information provided to the North Charnwood Primary Care Group should be reviewed so that it does not include patient identifiable information.

Referral systems available to the health authority

3.60 The health authority has an agreed framework for dealing with causes for concern about a doctor's clinical or professional practice through its reference committee. The reference committee has been established in line with NHS guidance.

Reference committee

3.61 Because the new NHS complaints procedure separated disciplinary issues from complaints, health authorities were tasked with establishing disciplinary procedures.⁵ In July 1996 the health authority board considered a framework for initiating disciplinary proceedings and for dealing with professional issues and fitness to practice, as they relate to primary care.

3.62 The regulations required the establishment of a reference committee to consider causes for concern, which included the allegations of a breach in terms of service. Where remedial action was identified, the reference committee could:

- recommend informal remedial action
- refer the matter to:
 - a discipline committee (administered by a neighbouring health authority where reciprocal arrangements are provided) and/or
 - NHS tribunal
 - a professional regulatory body, for example, GMC and/or
 - the police

The board delegated authority to the reference committee for consideration of these issues.

3.63 With the introduction of the GMC's revised professional performance procedures⁶ the health authority board reviewed reference committee arrangements. Revised procedures included the addition of a professional committee to oversee and consider causes for concern. For example:

⁵ Medical (Professional Performance) Act 199

⁶ EL (97)78. The management of doctors with problems

- persistent poor performance in a single area
- evidence of global poor performance
- health issues

3.64 Under these revised arrangements, the recommendations made by the professional committee are then considered by the reference committee which decide whether:

- there should be a referral to a discipline committee
- there should be a referral to the NHS tribunal, regulatory body or the police (or more than one)
- there should be a referral for remedial action; or
- no action is necessary

We were concerned to note the reference committee does not report its decisions to the board, which only receive a note of the decisions by copy of the minutes of a sub committee of the health authority. In the case of Peter Green this is particularly relevant since in our review of board papers, we found no evidence of a formal agenda item to discuss the issues arising.

3.65 Current regulations do not allow health authorities to suspend GPs. Their only recourse is to persuade a GP to refrain from practise pending the outcome of further investigation by the GMC or NHS tribunal. There are currently two routes to suspension following consideration by the reference committee. These are:

NHS tribunal

3.66 The NHS tribunal was established under Section 46 of the NHS Act 1977. Referral to the tribunal must be on the grounds that the continued inclusion of the person's name on the medical list "would be prejudicial to the efficiency of the services in question". The burden of proof required by the tribunal is similar to that in criminal proceedings, that is, "beyond all reasonable doubt".

3.67 The powers of the tribunal were extended in 1995 to temporarily suspend a practitioner from a list. Suspension can only be from the general medical list, that is, practising as a GP. However the doctor could be employed in another capacity, for example as a locum or a clinical assistant in a hospital or community trust. At the time of the investigation there were proposals to abolish NHS tribunals.

General Medical Council

3.68 The GMC have legal powers to protect the interests of the public, the most severe sanction being to strike a doctor off the medical register and thus removing the doctor's right to practice medicine. The GMC can take action when:

- there is an allegation of serious professional misconduct
- a doctor's professional performance may be seriously deficient
- a doctor with health problems continues to practise whilst unfit
- a doctor is convicted in the courts of a criminal offence.

3.69 The GMC also emphasise that all doctors have a duty to act quickly to protect patients from risk if they have reason to believe that a colleague may not be fit to practice.

Issues arising out of the health authority's reference committee

3.70 The decision taken by the reference committee to refer the partners of the Pinfold Gate practice to the GMC in July 2000, and the way it was notified to the GPs by the health authority immediately following the trial of Peter Green, was an issue which partners raised with CHI. As the issues have a direct relevance to the terms of reference of the CHI investigation, they are reported here.

3.71 The reference committee was convened following a written request from the Trent regional office on 22 May 2000. The purpose was to consider whether action should be taken (in line with agreed health authority policy) against any, or all, of the former partners of Peter Green. This was because they had not referred Peter Green to the GMC before 8 July 1997. In relation to the organisation of the reference committee, and the communication of its decisions, there were several key points:

- i. the issues relating to Peter Green were long running and multi faceted
- ii. consideration of whether practice partners should be referred to the GMC was at the request of the Trent regional NHS executive office of the Department of Health
- iii. because membership of the reference committee as defined in the agreed health authority policy excluded all other executive directors by virtue of their previous involvement in the case, a director who had no previous experience of chairing such a committee was nominated its chairman
- iv. while within the agreed health authority process, the health authority was not obliged to inform the practice partners that a reference committee had been convened, the health authority's legal advisers were also clear that it would be prejudicial to the trial to do so
- v. the letter to each partner, and the referral letter to the GMC, was posted at the same time

- vi. because there had already been considerable anxiety and publicity about the events leading to the arrest of Peter Green, a member of the health authority board felt that referral to the GMC would not impact dramatically on the partners, but clearly this was not the case

3.72 We were of the view that the decision of the reference committee was appropriate and reasonable. Immediately before the conclusion of the trial, however one of the partners was alerted “off the record” that a letter to each partner was awaiting signature on the director of public health’s desk, pending the outcome of the trial. This posed a serious problem in the minds of the partners about confidentiality within the health authority. We also note that the partners:

- felt the legitimacy of the reference committee was called into question by the intervention of the regional office
- believed the decision did not accord with natural justice or courtesy, nor did it take account of previous endeavours to develop professional working relationships between the health authority and the practice
- could not understand why the health authority should take action in July 2000, almost 3 years after the issues specific to Peter Green became the subject of his referral to the GMC and a police investigation, in which they had co-operated fully

Conclusions

3.73 It was clear to CHI that feelings of anxiety and bitterness about this issue remain, and the relationship between the health authority and the partners were strained. While we are of the view that the decision of the reference committee was appropriate and reasonable, we conclude that the way in which the process was handled, for example, its timing and the exclusion of the partners, lacked sensitivity during a period of high anxiety.

3.74 Although the reference committee procedures have been established in line with NHS guidelines, in the circumstances highlighted above, the health authority might wish to consider the rules on membership of the committee so that in the case of a potentially long, complex and high profile investigation they do not exclude the most appropriately experienced health authority director. Consideration should also include reporting arrangements to the health authority board.

Discussion

3.75 As we have previously highlighted the concept of monitoring the quality of general medical services was not introduced until the establishment of FHSAs in 1991. Although good progress was made in Leicestershire, regular and systematic organisation and clinical audit were at an embryonic stage in general practice in the 1990s.

3.76 Other than through discussion at the practice meetings, no arrangements were put in place in the Pinfold Gate practice which enabled partners to monitor effectively progress of the *back project*, as it extended beyond the two year period and concerns started to be raised. While a protocol was put in place in response to those concerns, and agreed by all partners, no mechanisms were established to audit the implementation of the protocol, for example, chaperoning of patients, audit of patient notes. Such audit should form part of a wider framework for monitoring the quality of patient care and will be significant in rebuilding public confidence in the service.

3.77 Even where practices are well regarded within their community, our findings highlight the weakness of a system where groups of clinicians work in isolation and where there is a lack of peer review and no explicit monitoring and audit of organisation and clinical practice to assure quality.

3.78 The expectation that health authorities will continue to improve the quality of general medical services remains. However, many interviewees questioned the ability of a health authority to account for quality when there are no direct line management arrangements between health authorities and general practice, and when health authorities are limited in the scope of monitoring and audit that can be specified. For example, in relation to complaints, health authorities can only require the receipt of global anonymised information, not the detail, both within and across practices, to enable them to monitor trends.

3.79 Even within the context of clinical governance arrangements, more detailed information is only available on a voluntary basis. This is considered further in chapter 4.

4 | Could the abuse happen again?

Introduction

4.1 In this chapter we consider key themes arising out of our findings, examine systems that have evolved to develop and manage clinical governance and primary care groups, and ask the question “could the abuse happen again”? That is, are there systems in place to detect abuse and prevent it from continuing?

Themes arising out of our findings

4.2 Emerging themes highlight the need for:

- i. greater clarity about the accountability of GPs for the quality of patient care, both individually and collectively, and explicit arrangements for auditing practice
- ii. strengthening of NHS regulations, which will enable health authorities to be more specific about the scope of information it requires from primary care to facilitate effective monitoring and audit of practice
- iii. where there is cause for concern, regulations should permit the health authority to take swift interim action, pending investigation by the GMC, to protect the interests of patients
- iv. explicit and consistent and mandatory policies in primary care for:
 - the logging and tracking of anonymous and informal concerns to facilitate the identification of a pattern of potential concerns. Such a system to be held separately, but reported in tandem with, other complaints information
 - evaluation of complaints and untoward incidents, maximising feedback from patients, practitioners and managers
 - regular audit of organisation practice, for example, patient appointment systems, and regular audit of clinical practice, for example, critical incident and near miss reporting and analysis
- v. explicit links between statutory bodies, for example, the police and health authorities, to enable speedy identification and discussion of potential problems
- vi. effective communication strategies between the NHS and public in high profile events of public concern
- vii. accessible and easy to use whistle blowing system, which enable staff to voice their concerns

4.3 Much of this is not new to the NHS, and indeed discussion of some of the issues and new mechanisms to deal with them are currently being debated at a national level. The key issue for CHI however, was whether changes through the introduction of clinical governance in the latter part of the 1990s have made it significantly less likely that professional misconduct or criminal activity can continue undetected. We now consider these new arrangements.

Clinical governance

Background

4.4 Clinical governance is the framework for the NHS to continually improve the quality of patient care. It is a relatively new concept and applies to all sectors of the health service¹. Health authorities are tasked with promoting, supporting and developing clinical governance among all local NHS organisations within their area. A key factor is the establishment of primary care groups², their successor organisations, primary care trusts, and their role in developing clinical governance in primary care.

Developing clinical governance

4.5 Arrangements in place at health authority level to develop clinical governance include:

- a strategy providing a monitoring framework for the implementation of clinical governance, including the reporting of adverse incidents, complaints, mental health inquiries, and continuing care appeals
- a quality committee, chaired by a non executive director of the health authority which oversees the development and implementation of the quality strategy and includes lay representation specifically from the CHC
- an established untoward incident reporting policy through which the health authority requires quarterly critical incident monitoring reports from primary care groups
- service level agreement between the health authority and the primary care audit group (PCAG), the objectives of which are to:
 - facilitate clinical audit in primary care, in particular priority areas identified in the local health improvement programme (HIMP)
 - support primary care groups/primary care trusts in implementing the audit components of clinical governance

4.6 Working together, the health authority and the local medical committee have issued guidance notes for doctors. The guidance comprises one document covering issues such as intimate examinations, chaperones, and administration of Midazolam.

4.7 Guidance has also been introduced about what to do if someone, for example a member of staff, has serious cause for concern. The health authority defines serious

¹ The new NHS. Modern and Dependable. Department of Health, London.

² HSC 1998/065. Establishing Primary Care Groups

cause for concern in policy documents as behaviour that is approaching the level where referral to the GMC is likely, for example, actions that threaten to harm the patient's well being. A summary leaflet of the guidance has recently been published³.

4.8 An interim appraisal system for GPs pending guidance to be issued by the GMC as part of their proposals on revalidation⁴, has been introduced by the health authority.

Conclusions

4.9 The development of clinical governance has been a high priority in Leicestershire and arrangements are progressing well. Close liaison has been maintained with the local medical committee who have worked with the health authority and general practice in the implementation of policies, for example, guidance notes on chaperones.

4.10 The health authority question and answer leaflet *Performance of a colleague giving cause for concern? What you should do* is a good example of simple, factual information to support policy and practice for those working in primary care.

North Charnwood Primary Care Group

Background

4.11 At the time of the investigation there were 10 primary care groups in Leicestershire. The Pinfold Gate practice is part of the North Charnwood Primary Care Group.

4.12 North Charnwood Primary Care Group was established on 1 April 1999 as a sub committee of the health authority. All GP practices must belong to a primary care group. Arrangements are well in hand for primary care groups in Leicestershire to progress towards primary care trust status although this will involve the merger of some primary care groups. Primary care trusts will encompass many of the services currently provided by community trusts. While GPs will retain independent contractor status and practice staff will remain employees of the general practice, attached staff and many of the staff currently employed by the community trust in Leicestershire will transfer their employment to a primary care trust.

Organisation and management

4.13 The chairman of the primary care group is accountable to the chief executive of the health authority for the management of the primary care group and development of clinical governance. A senior nurse employed by the primary care group has been appointed as the clinical governance lead for the primary care group, and is responsible for quality, with support from a GP.

³ *Performance of a colleague giving cause for concern? What you should do*. Leicestershire Health Authority, January 2001

⁴ General Medical Council. Revalidation process

Clinical governance arrangements

4.14 The primary care group board oversees the development of clinical governance within the framework of a development plan agreed with the health authority. Objectives specific to each practice are published in a table format to enable comparison. The primary care group also produces an overview of achievement/compliance with the clinical governance framework, for comparative purposes, within the primary care group. The development plan for North Charnwood includes plans for:

- clinical risk assessment
- identifying and supporting practitioners who may benefit from professional development
- involving service users

4.15 A clinical governance forum comprising the primary care group clinical governance lead from each practice meets regularly to consider and review progress in achieving areas of agreed development within the clinical governance framework, and to discuss areas of concern. There was an expectation from people talking to the team that this group would be a conduit through which areas of difficulty would be discussed, for example, trends identified through untoward and critical incident reports. The general manager of the North Charnwood Primary Care Group confirmed that this was so, the purpose being to discuss and facilitate a resolution of the concerns raised.

4.16 The accountability framework agreed with each primary care group comprises formal written agreements. Within North Charnwood all 10 practices have signed up to these agreements. Examples include:

Concordat

4.17 The concordat recognises the independent contractor status of GPs but promotes agreement between the primary care group and the GPs and other professionals working in primary care. Within the concordat each practice has a named person for:

- i. leading clinical governance
- ii. managing key areas within the practice, for example, repeat prescribing, child protection, health and safety
- iii. organisational fitness, for example, implementing the practice blue print, Health Quality Service (HQS) monitoring.
- iv. critical incident reporting, monitoring and action
- v. team appraisals

Organisation development

4.18 All practices in North Charnwood have completed the HQS process. Plans are being implemented to develop the blue print organisation audit to include some clinical standards. At the time of the investigation, six of the 10 practices in North Charnwood had completed the blue print organisation audit.

Policy issues

4.19 Frameworks for developing policies through primary care groups have also been devised. Several policies relevant to the CHI investigation are in place within the North Charnwood Primary Care Group and include:

Complaints procedure and critical incident reporting

4.20 The North Charnwood Primary Care Group has a framework complaints procedure based on current NHS guidance for use by all practices in its area. Although not formalised as part of a committee structure, a small group, including the general manager and chairman of the primary care group, review complaints and untoward incidents.

4.21 The review includes consideration of the elements of the complaint, specific to the doctor, and the follow up action required. This enables an analysis of trends of concerns raised primary care group wide. While the review comprises information received from each practice, it relies on that information being provided on a voluntary basis from individual practices and individual practitioners.

4.22 The clinical governance forum subsequently receives an anonymised primary care group wide report of complaints and untoward incidents. Any identified action is managed and progressed as agreed by the forum, which could include referral to the health authority. As noted previously, there is an expectation that clinical governance leads will feed in concerns from their own general practice.

Whistle Blowing

4.23 A whistle blowing policy is in place in North Charnwood practices, and is in line with NHS guidance⁵. The policy does not however provide the telephone numbers of other bodies, for example, *Public Concern at Work*, whereby staff can obtain independent advice if they feel unable to speak to someone within their own organisation.

4.24 NHS guidance proposes that initially a member of staff should raise a concern with their line manager. Two key points were made to CHI:

- GPs do not have line managers
- in a small organisation such as general practice, where many staff are also direct employees, staff may feel uncomfortable about raising a complaint or challenging the clinical practice or behaviour about someone with whom they have to maintain a working relationship

⁵ HSC 1999/98, Public Interest Disclosure Act 1998. *Whistle blowing in the NHS*.

4.25 The guidance also propose that a senior manager or non executive director should have specific responsibility for addressing concerns in confidence, which need to be handled outside the usual management chain. This is a system the primary care group could establish, and to which practice staff would have access, once it achieves trust status. Other organisations have appropriately addressed the concerns raised above. For example, we noted Leicestershire County Council had introduced a policy⁶, which was more flexible in that a concerned member of staff could select any senior manager in the county council to approach about that concern. That senior manager then takes responsibility for ensuring the issue is taken forward. This approach accords with the policy adopted for CHI's own employees.

4.26 We also heard about the staff ombudsman scheme, which has been in place in the community trust (and its predecessor organisation) since 1992. The staff ombudsman exists as a source of confidential advice and support to staff who have concerns about patient care, but who, for whatever reason, feel formal management routes are not appropriate or have been exhausted. Key aspects of the role are:

- an ability to inspire the respect and trust of staff at all levels of the organisation
- to be as independent of both staff and management as possible
- unrestricted access to all levels of the organisation

The importance of such open procedures was clearly demonstrated to us during our investigation.

Chaperoning

4.27 A framework policy exists from which to develop a common approach across the primary care group. We noted that a chaperoning policy had been in place in the Pinfold Gate practice since 1996. This was developed following discussions between partners about a patient complaint which triggered the drafting of what was termed a *Sexual Conduct Policy*. When we visited Pinfold Gate we noted that clear notices about chaperoning were displayed throughout the practice.

4.28 CHI heard that the Pinfold Gate practice administrative staff are frequently asked by partners to act as a chaperone. Several staff members felt embarrassed about this, and also felt patients would be more comfortable if a nurse undertook this role. However, the availability of nurses to do this at all times may be difficult to achieve. We also noted that Peter Green had not adhered to the practice policy in relation to chaperoning, and this raises the issue of monitoring compliance with agreed policy.

4.29 One means of ensuring that people adhere to chaperoning policies is to facilitate an understanding of the importance of chaperoning to protect the interests of both patients and professionals. We concluded that a structured approach to training and awareness for all staff in primary care, clinical and non-clinical, and should be a priority.

⁶ Employee Information Bulletin. No. 96. *How to raise issues which cause you serious concern*. Leicestershire County Council.

Child protection policies

4.30 The health authority designated child protection advisors (a senior doctor and a senior nurse) undertake annual child protection visits, reports of which we reviewed. While the focus of the visits was on acute services, liaison between accident and emergency and the community trust, the paediatric social work department, training programmes, and audit of child protection procedures was also considered.

4.31 A multi agency approach to child protection issues is essential. In current guidance⁷ however health authorities are responsible for identifying a senior paediatrician and senior nurse with a health visiting qualification to take the lead on all aspects of the health service contribution to safeguarding children. NHS trusts (including primary care trusts) are also required to have a named doctor and a named nurse to take a professional lead on child protection issues. Under the guidance primary care staff should be included in awareness raising and training on these issues.

4.32 While CHI found no evidence of direct concern in relation to implementation of child protection policy issues, our findings highlight the importance of awareness to trigger discussion of concerns. In these circumstances a structured approach to child protection awareness and training would be timely and support and enable staff to identify potential problems.

Conclusions

4.33 As a sub committee of the health authority, North Charnwood Primary Care Group is developing a consistent approach to the implementation of clinical governance in primary care. This includes the sharing of anonymised information to compare different stages of development within each practice. While recognising that much of what can be achieved within primary care relies on the willingness of individual practices, and individual practitioners, to participate, the implementation of clinical governance has been approached with enthusiasm and in a spirit of collaboration and learning. The local medical committee have played an important part in this.

4.34 While the use of whistle blowing policies should be regarded as a last resort phenomenon, they warrant further review in Leicestershire, particularly in light of the events in Loughborough. For example, explicitly providing access to support and advice from outside of the organisation's management chain. This could include access to *Public Concern at Work* and a non executive board member. Examples already exist in Leicestershire and are referred to in paragraphs 4.25. and 4.26.

4.35 CHI welcomed the high profile given to chaperoning, which is particularly important in building public confidence. A review locally, of which groups of staff within general practice should be asked to chaperone, would be timely.

⁷ Department of Health, *Working Together to Safeguard Children*, December 1999

4.36 A more structured approach to child protection awareness and training for all staff in order to support them, as well as enable them to identify potential problems, and develop a consistent approach to policy implementation, would be appropriate.

The patient experience

Introduction

4.37 The method of contacting members of the public, and patients registered with Peter Green, and the issues arising are provided in appendix G. Some people contacting the team also commented on how CHI might improve access to information about their investigations for members of the public and publicise and manage their 0845 investigations information line. This is gratefully acknowledged. The comments made will feed into our revised framework for stakeholder involvement in investigations.

4.38 The main focus of our discussions with the public was in relation to complaints and the systems to enable comments and concerns to be raised, no matter what those concerns might be.

What people said

4.39 A member of the public talking to the team about complaints procedures suggested that when dealing with complaints, in an ideal organisation:

“There would be no sense of internal disharmony, inertia or lack of interest, but an open culture staffed by people trained to investigate concerns objectively and with a full understanding of the procedures”.

4.40 This view encapsulated what many people believed, although some expanded on the theme by stressing the importance of complaints being dealt with independently. Those with experience of making complaints, believed it was difficult for a member of staff to remain objective when that member of staff was an employee and a member of a small team, one of whom was being complained about. Other comments about complaints included:

For patients there is:

- a lack of clarity about complaints procedures and how to access them
- a lack of confidence in the openness of the system
- a need for consistency in the way in which complaints are dealt with

From NHS staff there should be willingness to:

- listen to concerns when they are raised and value the patient's view point
- address concerns objectively
- explain processes clearly and keep complainants informed of progress in investigating concerns
- provide speedy access to medical records

4.41 Other issues raised with CHI included:

- i. the difficulty for some people in understanding the boundary of the doctor/patient relationship and the expectation that patients may trust their GP to do what is best for them
- ii. even in the inappropriate circumstances occurring in consultations between Peter Green and some of his patients, it is difficult for patients to question their GP - particularly so when people involved are young
- iii. concern that within the current regulatory framework, when a doctor is removed from the medical register there is nothing to prevent the doctor from practising in another profession, for example psychotherapy, hypnotherapy
- iv. no consistent mechanism for circulating alert information when there is concern about practitioners in primary care
- v. a small number of people believed that Peter Green may have had an accomplice, but neither the police nor the health authority had found anything to substantiate this
- vi. many people expressed satisfaction about the service provided by Peter Green and his partners, but the CHI investigation was not established to examine the clinical competence of either Peter Green or his partners

The NHS complaints procedure

4.42 We are aware that a working party has reviewed the NHS complaints procedure and will be reporting shortly. There are several key issues arising out of our discussions with NHS staff and with patients and the public, which is relevant to that work:

- i. while several people articulated the need for an independent complaints system, not everyone agreed with this point of view, commenting that there should be a more open process within the NHS
- ii. whatever system is established following the national review, there should be direct patient involvement in structuring the process at a local level

- iii. there should be one clear complaints system for all NHS bodies, including general practice, to which all are held accountable
- iv. clear, unambiguous, national standards for handling complaints should be developed with mechanisms for auditing compliance
- v. all those working to support complainants, including those for example, working as advocates for the complainant, should work to the agreed standards
- vi. standards should include a process where people, including advocates for patients, have direct access to a named non executive trust board member, including primary care trusts - such fast track access to be based on clear criteria
- vii. explicit arrangements for reporting the audit of complaints at all stages of the process health authority wide, and on the public agenda, should be established and encompass issues raised by complainants and identify trends
- viii. independent lay input in the audit process
- ix. logging and tracking of concerns raised anonymously
- x. health authority wide there should be a means of performance managing the complaints system to ensure consistency of approach and a mechanism for tracking complaints about individual clinicians, and groups of clinicians, to monitor trends and areas of potential difficulty
- xi. training for staff dealing with complaints should have a high priority in each organisation and staff posts resourced to reflect the important role complaints information has in improving the quality of service

Conclusions

4.43 Our analysis identified a clear need for a complaints system which was managed and reported more consistently. To be effective it should provide explicit standards to which all those providing NHS services must work and, which are clearly understood by those wishing to make a complaint. Independent lay input should feature in the audit of complaints. Anonymous concerns should be logged and tracked.

4.44 A major weakness of the current system is the inconsistency between general medical service and hospital and community health service procedures and the way in which complaint issues are reported at board level. More explicit reporting arrangements at board level to include anonymous and informal comments, and direct access to a non executive board director for specific complaints would do much to build confidence in, and enhance, the process.

4.45 A study undertaken by the University of Sheffield⁸ reported that there were mixed views about the reliance on complaints as an indicator of poor performance. There are several measures and sources as potential indications that a GP is falling

⁸ *Measures to assist GPs whose performance gives cause for concern*, University of Sheffield, September 1977

below recognised standards. While we support his view, we concluded that the aim should be to ensure complaints are recorded and monitored effectively, and dealt with appropriately and swiftly. Nonetheless a complaints system, no matter how well designed will not always detect issues of professional misconduct or criminal activity. Additional mechanisms which support and encourage all staff to participate in peer review, and to facilitate the expression of concerns within an agreed framework, are also required. Whistle blowing policies should underpin the processes as a last resort phenomenon. In this way staff at all levels of the service, as well as patients, should be enabled to voice concerns.

Discussion

4.46 Our review of the implementation of clinical governance in Leicestershire and its development in primary care led us to conclude that North Charnwood Primary Care Group had pushed the boundaries beyond what many may have achieved. This was evidenced by the willingness of many interviewees to discuss the lessons to be learned from the experience of events in Loughborough.

4.47 Nonetheless, interviewees referred to clinical governance in primary care “as a lot of investment in raising the ceiling, but no one is looking at the floor”. This accords with the view of many who described the huge energy and commitment to developing and raising standards within primary care. This was coupled with frustration that neither the health authority nor the primary care group could compel all those working at practice level to participate and contribute to the development work, and ultimately to work to those standards.

4.48 Additionally, a clear distinction between unintentional poor performance (which clinical governance arrangements should address) and professional misconduct and criminal activity (which clinical governance is not designed to address) is required. Other high profile cases, for example, those of Harold Shipman and Rodney Ledward, reinforce the importance of this distinction, and the difficulties of detection within the current system. Thus we concluded that despite the strong commitment to develop clinical governance in primary care there remains the potential for professional misconduct to go undetected. The key is to minimise such activities continuing undetected by introducing preventative measures. This can only happen if lessons are to be learned from the unacceptable patient experience we have recorded in this report.

4.49 Our findings highlight the need for a mechanism for auditing what happens behind the consulting room door. This reinforces the need to monitor and audit organisation and clinical practice and must include the patient perspective. Such perspectives must go beyond the patient satisfaction survey approach. We referred earlier to the development of the blue print process, which is being developed to include clinical standards, but we suggest consideration must also be given to additional tools to facilitate the patient perspective in the audit process.

4.50 Patients and their families (in respect of minors) also need access to simple information about what they should feel entitled to when they visit their GP. Such

information is not intended to undermine the doctor/patient relationship, but should be a means of more accurately reflecting the boundaries of the doctor/patient relationship. This is especially relevant in primary care. A project⁹ funded by the NHS Executive South East to examine the incidence of sexual abuse of patients by professional staff, identified that professionals most at risk of being accused of, or found guilty of, sexual misconduct because of the clinical context of their work, are GPs, psychiatrists, clinical psychologists and community psychiatric nurses.

4.51 These professionals tend to work in small teams, and care for the more vulnerable members of our society. These perceptions also reinforced the concern expressed to CHI about doctors removed from the medical register being able to practice in another profession, for example psychotherapy, hypnotherapy.

4.52 Our main finding has been the scattered nature of the 'pieces of the jigsaw'. This demonstrated the lack of overview and co-ordination of concerns as they emerged. A process, with clarity about responsibility for the process, within current general management arrangements, should be established to enable discussion and planning for rapid resolution of concerns. Such a process could be based, for example, on the principles of ACPCs and mechanisms evolving to check for abuse for vulnerable adults. Just as an ACPC is called when there is concern about the welfare of a child, so could people from different organisations be called together to discuss the issues when there is concern about the potential professional misconduct or criminal activity of a clinician.

4.53 Within the process there should also be a mechanism:

- for ensuring that patients or staff who come forward are supported throughout, and have a clear understanding of what will be expected of them should matters progress to prosecution
- to address the issue of speedy access to medical records

The proposal assumes the potential for a small number of cases, but such a process would act as a catalyst for ensuring timely and appropriate action.

4.54 We recognise that the GMC is actively reforming its structures and processes. Where issues of potential professional misconduct or criminal activity are highlighted we suggest mechanisms within the new arrangements should include a fast track process so that cases at the extreme end of professional misconduct can be dealt with swiftly. Thus the interests of patients would be the prime factor. The GMC should also consider the logging and tracking of anonymous comments and concerns in the process.

4.55 In addition to our comments on complaints in paragraph 4.42 a national database of complaints and concerns, based on a complaints monitoring system that includes anonymous and informal concerns, would enable health authorities to carry out annual reviews and monitor trends. Data collection should be to an agreed

⁹ *Sexual misconduct in the healthcare professions. A breach of Trust.* Prepared by Peter Boyland on behalf of the NHS Executive, South Eastern Region.

formula nation wide. Consideration might include adding this data to the proposed national system for reporting adverse events and near misses.

4.56 While we did not detect any failures in the implementation of child protection procedures, discussion with NHS staff highlighted the issue of awareness and training in child protection issues. The health authority have an established system whereby the designated doctor and designated nurse in child protection undertake regular inspections. Responsibilities outlined in the guidance include awareness raising and identifying training needs. There needs to be a mechanism to ensure these posts are universally in place as we believe they are an essential element of joint working arrangements on child protection issues.

4.57 Patient information to facilitate an understanding of the patient/doctor relationship, and what the patient should expect when visiting the doctor, would be timely. The information could also reflect individual and professional accountability for the performance of professional peers, as outlined in the GMC's *Good Medical Practice Guide* and could also be linked to the mandatory display of information in all practices on complaints, and specific information on the patient/doctor relationship, for example chaperoning.

4.58 Considerable anxiety was expressed to us about the role and purpose of the health authority's help line. A national handbook providing guidelines on the establishment of help lines in the event of critical incidents and untoward events should be developed to assist NHS organisations in the speedy planning and implementation of a help line in periods of high profile events.

5 | Putting the jigsaw together

Introduction

5.1 In this chapter we present our recommendations grouped for consideration at a local level and a national level. Some of our conclusions and recommendations complement proposals in the *NHS and Social Care Act* and *Building a Safer NHS for Patients*.¹ For example, a new national system for reporting adverse events and near misses across primary and secondary care is being progressed through the National Patients Safety Agency, and a new independent advocacy service to provide support to those who wish to complain.

5.2 Other measures are being introduced to deal with areas of poor clinical performance through the National Clinical Assessment Authority (NCCA) and through the introduction of revalidation by the GMC linked to NHS appraisal. These are welcomed. We are concerned however that measures may be reactive and will not always enable the early detection of the potential for professional misconduct or criminal behaviour. A weakness also remains in the system as health authorities are unable to define the scope and detail of information they require from general practice in order to audit clinical practice.

5.3 The purpose of our recommendations at a national level, therefore, is to limit the potential for professional misconduct or criminal behaviour continuing undetected by introducing preventative measures, and to facilitate the expression of concerns by both patients and staff.

5.4 At a local level, the recommendations aim to build on progress achieved to date in Leicestershire in developing clinical governance in primary care.

Recommendations

At a local level:

5.5 We acknowledge that the events leading up to, and subsequent to, the conviction of Peter Green have had a lasting and traumatic effect on some patients and families. The events have also had a damaging impact on the health authority, the primary care group and the practice, but that experience has been used positively in planning the implementation of clinical governance in Leicestershire, and particularly in the North Charnwood Primary Care Group.

¹ *Building a safer NHS for patients. Implementing organisation with a memory*. Department of Health. 2001.

5.6 Further action should be taken however to build on what has been achieved to date. In particular those working in the NHS in Leicestershire need to acknowledge that it is everyone's responsibility to ensure that the patient interest is central to their work and that organisational structures, for example, independent contractor status, must not be a barrier to achieving it.

5.7 Patients, the public and NHS staff remain concerned about the events leading to the conviction of Peter Green, and for those patients and families directly affected there continues to be considerable distress. The potential for *a credible person doing incredible things to patients to whom he had a duty of care* is unacceptable. There needs to be a public acknowledgement of this and a commitment for all NHS agencies to work together to try and ensure such events do not occur again.

We therefore recommend that the health authority should:

5.8 Review the way in which complaints are reported and monitored so that lessons are learned through the process to improve the quality of patient care. Such a review should build on the system developed by North Charnwood Primary Care Group. A key feature should be a framework for sharing sensitive information, which maintains confidentiality, and specifically ensures that:

- the format of the complaints form completed by general practice for primary care groups does not include the patient's name, but provides a mechanism to monitor trends and areas of potential or consistent concern relating to individual practitioners or groups of practitioners
- the process facilitates monitoring of action taken and learning for general practice health authority wide
- while maintaining confidentiality, more explicit and regular reporting of complaints at health authority board level

5.9 Explore procedures with the Leicestershire LREC to ensure that the new *Research Governance Framework for Health and Social Care* has been implemented in line with the guidance. As a priority progress the establishment of a register of research and development activity within Leicestershire to be available on the health authority intranet site with access for all NHS staff in the health authority area.

5.10 Undertake an urgent review of the reference committee process, in particular its membership, so that the most appropriately experienced director is not excluded on potentially complex and high profile issues, which require rapid consideration and resolution.

5.11 Review the health authority's:

- communications strategy to ensure it reflects lessons learned from the issues arising out of the CHI investigation in chapter two
- whistle blowing policy so that there is explicit provision for access to support and advice from outside of the whistle blower's individual line management, for example through access to *Public Concern at Work* and a non-executive board member on each primary care trust

5.12 With local medical committee and primary care group/primary care trust leads:

- review organisation audit tools currently in use in Leicestershire, for example the blue print process, and the potential of other processes, for example those developed by the Royal College of General Practitioners (RCGP), or the *Investors in People* programme to facilitate a planned programme to audit agreed organisation standards in primary care. The process should include the views of patients, which go beyond the patient satisfaction survey. As a first priority the audit programme should include the administration of patient appointment systems, patient notes, and chaperoning policies
- review which groups of staff should act as chaperones
- agree a mechanism for identifying training needs for all staff in primary care from which an agreed training programme can be developed.

5.13 With the Pinfold Gate practice:

- explore outstanding relationship difficulties between the health authority and the GPs in the Pinfold Gate practice using lay conciliation to agree mechanisms for improved communication in future
- facilitate a structured team building exercise for all doctors and practice staff, including attached staff. As part of the exercise the practice should consider the role and purpose of team meetings

At a national level:

5.14 Current accountability arrangements between GPs and primary care groups/primary care trusts and health authorities are inadequate. They need strengthening so that organisational structures, for example, the independent contractor status, are not a barrier to ensuring a consistent improvement in the quality of patient care. We recognise that the *Health and Social Care Act 2001* should enable a strengthening of current regulations. Nonetheless distinction also needs to be made between identifying unintentional poor performance and identifying professional misconduct and criminal activity. New mechanisms must ensure that preventative measures are introduced to limit the risk of professional misconduct and criminal activity occurring undetected. To achieve this, implementation of the new regulations and other proposals at a national level need to take full account of CHI's findings.

We therefore recommend:

- i. in discussion with the Royal College of General Practitioners, establish greater clarity about the accountability of GPs individually and collectively as a practice and as a profession, to ensure the quality of patient care, and explicit arrangements for auditing practice
- ii. strengthening of NHS regulations, which will develop accountability between independent contractors and primary care trusts/health authorities, or their successor organisations. This should include:

- the right of health authorities to define the scope of information it requires from primary care to facilitate effective monitoring and audit of practice
 - regular audit of critical incident and near miss reporting which maximises feedback from patients, practitioners and managers
 - a mechanism to track compliance within general practice for reporting adverse events and near misses
 - powers, which enable a health authority (or its successor organisation) and/or the primary care trust to take swift action, for example interim suspension, pending investigation by the GMC or the NCAA
 - NHS guidance on issuing 'Alert Letters' to include areas of concern arising out of primary care
- iii. review of the regulatory framework so that the circumstances and services in which individuals currently removed from the medical register may continue to practice in another profession, for example psychotherapy, hypnotherapy, and the implications for patient safety are addressed
 - iv. establishment of audit trails for use of medicines in primary care which are consistent with the guidance incorporated in the controls assurance standard on medicine management dealing with safe and secure handling of medicines in acute services
 - v. establishment of health authority data bases (nation wide) to collate complaints and concerns to an agreed formula
 - vi. a mechanism for logging and tracking anonymous and informal concerns which may be held separately but should be reported in tandem with complaints information
 - vii. adding complaints data to the proposed national system for reporting adverse events and near misses
 - viii. the establishment of an audit system to monitor compliance with the guidance *Working Together to Safeguard Children*, specifically in relation to:
 - the appointment of a designated doctor and a designated nurse, currently at health authority level, with a responsibility for child protection issues
 - awareness raising and training for all those who come into contact with, or provide services to, children in primary care
 - ix. that recruitment of GPs is undertaken in line with best human resource practice and to agreed procedures. Openness and probity should be an integral part of the process. A feature of the process should include an assessor outside the general practice. Consideration might also include patient representation on the appointments panel

5.15 During the time leading to this investigation, Peter Green was able to persuade his partners and others that some people are unlikely to be believed. The current NHS complaints procedure contributes to a disempowering system for patients and places unreasonable restrictions on them. It lacks independent lay input in the investigation and analysis, and assumes an ability to articulate concerns with a degree of knowledge and perseverance that is unreasonable. A clearer commitment to ensure that patient's interests are central to all activities in the NHS is needed.

We recommend:

- i. the outcome of the review of the NHS complaints procedure and subsequent revised guidance should include elements of:
 - one system with explicit standards to which all NHS staff must work, and which are clearly understood by those wishing to make a complaint
 - a process where people, including advocates for patients, have direct access to a named non executive board director, such access to be based on clear criteria
 - direct patient involvement in structuring the process at a local level
 - explicit arrangements for reporting the audit of complaints at all stages of the process which includes issues raised by complainants and identifies trends health authority wide, and on the public agenda
 - include independent lay input in the audit of complaints
 - logging and tracking anonymous and informal concerns, which may be held separately, but reported in tandem with other complaints information
 - performance management of the complaints system to ensure consistency of approach and a mechanism for tracking complaints about individual clinicians, and groups of clinicians, to monitor trends and areas of potential difficulty
 - staff posts resourced to reflect the important role complaints information has in improving the quality of service, and training to support that role
- ii. In relation to the doctor/patient relationship the:
 - development of patient information to facilitate an understanding of the patient/doctor relationship and what the patient should expect when visiting the doctor. The information should be developed in consultation with organisations, which represent the patient interests. It should also reflect individual and professional accountability for the performance of professional peers as outlined in the GMC's *Good Medical Practice Guide*. In the context of this report, the Prevention of Professional Abuse Network (POPAN) would be an appropriate organisation to consult on the development of patient information
 - mandatory display of information in all practices relevant to the patient/doctor relationship, for example, how to complain, chaperoning
- iii. mandatory registration and monitoring of all research activities undertaken by health professionals outwith their NHS contract or general medical service

5.16 We acknowledge that no system can entirely prevent professional misconduct or criminal activity occurring. Nonetheless, it is incumbent on all those working in the NHS to introduce preventative measures to limit the risks to patients, and to ensure that where there are concerns, they are considered as swiftly as possible.

We recommend:

- i. the establishment of a process with explicit responsibility, within current management arrangements, to enable discussion and planning for rapid resolution of concerns. Such a process could be based, for example, on the principles of ACPCs and mechanisms evolving to check for abuse of vulnerable adults. Just as an ACPC is called when there is concern about the welfare of a child, so could people from different organisations be called together to discuss the issues when there is a concern about the potential professional misconduct or criminal activity of a clinician. The process should include:
 - a protocol to facilitate sharing of confidential information and access to medical records
 - a mechanism for ensuring that patients or staff who come forward are supported throughout, and have a clear understanding of what will be expected of them should matters progress to prosecution

For consideration by the Chief Medical Officers in England and Wales

5.17 Research should be commissioned nationally into the characteristics of health professionals who commit criminal acts, and the characteristics of the organisation, in which they are able to operate.

5.18 Mechanisms should be established for auditing trust and health authority compliance in establishing whistle blowing policies.

5.19 The issue of Midazolam being subject to stricter controls under the Misuse of Drugs Regulations should be considered for referral to the Home Office to seek advice from the Advisory Council on Misuse of Drugs.

For consideration by the GMC

5.20 The GMC is asked to consider:

- the establishment of fast track mechanisms so that cases at the extreme end of professional misconduct are dealt with swiftly
- mechanisms to log and track anonymous concerns to facilitate identification of patterns of potential concern
- how the GMC *Good Medical Practice* guide can reflect and be linked to our findings relating to the patient/doctor relationship and our recommendation 5.15.ii.

Proposals for CHI

5.21 The development of a national handbook for those working in the NHS outlining best practice in establishing help lines for patients and the public in the event of critical and untoward incidents, the use of which would be mandatory.

5.22 Clinical governance reviews to include consideration of reports from designated child protection doctors and designated child protection nurses in its review of quality assurance.

Next steps

5.23 An action plan arising out of the recommendations will be agreed with the Leicestershire Health Authority and the Department of Health following publication of this report.

Context to the investigation

Background

1. Services provided by GPs, dentists, high street opticians and pharmacists, and staff employed by them, are collectively referred to as “family health services”. In most circumstances these practitioners are not direct employees of the health service but are “independent contractors”.
2. Family health services are usually provided from health centres, GP surgeries, dental surgeries, or in the case of opticians and pharmacists in shop front premises in the high street.
3. Independent contractors can employ their own staff. In general practice, in addition to the administrative staff this may include a practice manager and practice nurses. Other staff who may work with GPs, for example, district nurses and health visitors are employed by a community trust, so are direct employees of the NHS. As NHS employees they will work to different terms and conditions of service, and this will almost certainly include different policies and procedures. These NHS staff, who may also work for more than one practice, are usually referred to as “attached staff”.
4. In recent years initiatives have developed for the employment of salaried GPs by the NHS. More recently, these initiatives have been progressed through pilot schemes for personal medical services (PMS) whereby GPs become salaried. These arrangements are in the early stages of development and are on a voluntary basis. Most GPs however remain independent contractors. When we refer to independent contractor status, we do so in the context of GPs, but recognise that others (dentists, pharmacists, opticians) also continue to work as independent contractors.
5. While the independent contractor status for most GPs has remained unchanged, systems for planning, administering and managing general medical services have evolved throughout the period under investigation (1977-1998). These are outlined below.

The GP contract

6. As independent contractors, GPs work to a national contract to provide general medical service to their NHS registered patients. They are not NHS employees but are paid various allowances and fees as defined in their terms and conditions of service. Some payments are fixed but others are dependent on the number of patients registered or on items of service delivered.
7. Before practising as a GP, a doctor must first be accepted on to the health authority's medical list. Such acceptance will only occur if the doctor has been appointed to a single handed (a GP working on his/her own) vacancy, or has been appointed to an existing partnership. Before being accepted on to the medical list, certain criteria must be met - the doctor must be fully registered with the General Medical Council and have a certificate of prescribed (or equivalent) experience from the joint committee on postgraduate training for general practice. Although the majority of doctors entering general practice from the mid 1970s to 1981 undertook vocational training voluntarily, it was possible to gain entry to the medical list without this before 1981. In 1981 vocational training became a legal requirement.
8. Significant changes were made to the GP contract in 1990. In particular, GPs were encouraged to provide additional services. Until that time the majority of GPs provided maternity care as an additional service for which they had to provide evidence of appropriate training if they wished to be included on the obstetric list. With the introduction of the new GP contract in 1990 a number of other lists were introduced. These included child health surveillance and minor surgery. However, to provide these services, appropriate criteria must be met - including training and appropriate facilities from which to practice. The health authority determines entry on to the various lists.

Local Medical Committees

9. Local medical committees have existed in much the same form since 1911. There is usually one committee in each health authority area. The committee is elected by GPs and is funded through a compulsory GP levy. It has a statutory role in that the health authority is required to consult the local medical committee on a wide variety of general medical service issues, including those relating to the provision of health care.

10. The local medical committee provides advice and support to practices and to individual GPs. The advice can range from resolving difficulties between GP partners to the legislative requirements of general practice. Support can also include accompanying and representing GPs who are the subject of independent reviews or disciplinary procedures.

Family Practitioner Committees (FPCs)

11. FPCs administered general medical service from 1974 to 1990. During their existence they had no officer members on its committee, the most senior member of staff post being that of administrator. Each committee comprised approximately 30 members (GPs, dentists, opticians and pharmacists). Initially the FPC was administratively and financially a sub committee of the then area health authority (AHA) but was accountable directly for the administration of its regulations to the secretary of state. In 1980/1981 the FPC became an autonomous body directly and solely accountable to the secretary of state.

12. FPCs had an administrative and planning function largely concerned with accessibility and service availability to the local population. They had no management or formal development role either in terms of a group of GPs working in partnership, or individual practitioners within that partnership. With regard to practice partnerships and partnership agreements, the FPC had no regulatory role and could not over rule decisions by GPs to sever partnership agreements. Indeed, many partnerships did not have formal written partnership agreements.

13. Provided a GP was already on the list and had adequate premises from which to practice a GP can become a single-handed practitioner. However where a single

practitioner gave up practice, for example, through retirement, the FPC could decide whether the practice should remain single handed, and if so, appoint a new GP with the involvement of the local medical committee.

14. In the mid 1980s, a planning and management role for FPCs was recognised in *Promoting Better Health* and this role was extended and formalised with the introduction of family health service authorities.

Family health service authorities (FHSAs)

15. In April 1991 FHSAs were introduced, and replaced FPCs. FHSAs were accountable to regional health authorities (RHAs). The arrangements included the creation of chief executive posts identified as general managers, filled by open competition. General managers were ex officio members of the FHSAs board and had a responsibility for implementing policy and service development, including the monitoring and review of family health services. Responsibilities also included instituting, controlling and monitoring suggested prescribing budgets for GPs and managing professional staff, for example, medical advisers, dental practice advisers.

16. The new arrangements also included the establishment of a board comprising 11 members under the leadership of a chairman appointed by the secretary of state of health, and requirements of FHSAs to establish a medical audit committee.

17. An operational planning cycle was also established, compatible with the hospital and community health services system of planning, based on the preparation of two year rolling operational plans. FHSAs were required to consult district health authorities when drawing up these plans.

District health authorities (DHAs)

18. During a substantial period relevant to the CHI investigation, health authorities were statutorily responsible for the planning and management of hospital and community health services. There was no direct or indirect link with general medical services. It was not until the establishment of FHSAs in 1991 that formal connections between the two began to evolve when regional health authorities (RHAs) were given the responsibility to ensure FHSAs plans were co-ordinated with those of health authorities.

19. FHSAs and health authorities continued to function separately until proposals for them to jointly plan and commission hospital and community health services were implemented in 1994/1995. Nonetheless, they maintained separate statutory performance management and monitoring arrangements through their individual boards until formal merger with one health authority board in April 1996.

20. More recently health authorities in England have been given responsibility for the establishment and performance management of primary care groups and their successor organisations primary care trusts (PCTs). PCTs will have a major role in commissioning and monitoring health services. While all GPs are part of a primary care group, and subsequently a PCT, most GPs retain independent contractor status.

Regional health authorities (RHAs)

21. The functions for which RHAs became responsible in 1991, in relation to primary care, included:

- appointing FHSA members
- allocating funds to FHSAs
- dealing with entry and exit of GP practices to GP fund holder schemes
- monitoring plans, co-ordinated with those of health authorities
- reviewing the performance of FHSAs

A key role for RHAs was to secure the maximum collaboration between FHSAs and health authorities. In 1994 proposals were introduced to abolish RHAs, and replace them with NHS Executive offices.

22. Interim arrangements came into place in 1994 advising on the legal and management arrangements during the transitional period from 1 April 1994 until RHAs were abolished in 1996. During this period RHAs and NHS Executive offices (regional offices) existed in parallel as separate legal entities but with a joint management structure. During this period RHAs retained their responsibilities in relation to primary care.

NHS Executive offices (regional offices)

23. Regional offices were established in England in April 1996. The purpose was to streamline NHS performance management arrangements across hospital and community health services and general medical services. Responsibilities include:

- ensuring the implementation, communication and co-ordination of national policy with the NHS and others working with the NHS
- managing the performance of the NHS in their region and setting the strategic framework within which local discretion is encouraged

These responsibilities, with others, have remained in place since 1996.

NHS complaints procedures

Service committees

24. In the 1970s and 1980s FPC service committees (and subsequently FHSA service committees) handled patient complaints about primary careⁱ. The rules were specific in that the committee could only investigate alleged breaches in terms of service (that is, contractual matters) and these, together with the time scales for making a complaint, were rigidly applied. Guidance assumed that the FPC would not process anonymised complaints or complaints not submitted in writing. The chairman of a service committee could consider a complaint out of time although this would require the consent of the GP being complained against or a decision by the secretary of state for health.

25. Once the chairman of the service committee had accepted the complaint, it was handled by an exchange of correspondence. A sub committee, having reviewed the correspondence would decide if there should be a hearing by a service committee. A service committee hearing was required to follow a strictly prescribed format and would report its findings and recommendations to the FPC. The FPC had the power to accept or reject the recommendations. Action which could be taken included:

- a warning to the GP to comply more closely with terms of service.
- a financial penalty, but if the sum involved was over £500 the service committee recommendation required ratification by the secretary of state for health
- referral to an NHS tribunal

26. The FPC could also refer a complainant direct to the NHS tribunal but this would necessitate an investigation of the concerns raised before referral. The FPC had no powers to refer a breach of terms of service to the GMC.

Conciliation

27. In 1990 the complaints procedure was amended to provide an opportunity for complainants to pursue an issue not specifically related to terms of service. The amendment included an informal stage based on conciliation, which required both the patient and the GP to agree to the process before a conciliator was appointed. The requirement to put the complaint in writing remained. If the concern related solely to professional misconduct then the complainant was required to go direct to the professional body, for example, the GMC.

New complaints procedure

28. Following a national review of complaints processes by the Wilson Committee, a new NHS complaints procedure was introduced in 1996. This separated patient complaints from the disciplinary process. An important aspect of the new procedure was local resolution. It was intended that those directly involved in caring for the patient should try to resolve concerns with the patient and/or relatives swiftly and with as little bureaucracy as possible. At local resolution it is also

possible to involve lay conciliation. If local resolution is unsuccessful, in the case of primary care, the complainant can request a review by a health authority convenor. The role of the convenor is to examine the complaint and consider whether the establishment of an independent review panel, to consider the complaint further, is appropriate.

29. Once the full procedure has been followed, and if the complainant remains dissatisfied, then the complainant has recourse to the Health Service Ombudsman whose role was extended in 1996 to include consideration of complaints about clinical practice.

30. The key objectives of the new procedure were that those working in the NHS listened to complainants, acted on the issues raised and learned from the patient experience to improve the quality of service. Nonetheless, while health authorities were expected to monitor that general practice is providing a satisfactory practice based procedure, they were not expected to be routinely informed about the detail of individual complaints. They were simply required to collate statistics relating to the number of complaints received by practices together with the number of requests for independent review, and to publish these statistics on a health authority wide basis. Additionally, while the guidance proposed health authorities should provide this information to regional offices, it was not compulsory within the statutory instrument, which established the procedure. Thus, unless regional offices were able to negotiate receipt of complaints information, the opportunity was lost for monitoring complaints (albeit in a limited form) on a region wide basis.

31. The NHS complaints procedure, as introduced in 1996 remains, although at the time of the CHI investigation, the procedure was under review at a national level.

Loughborough Investigation Team

Team members:

Mr Alan Burns (NHS manager member)
Chief Executive
Cambridgeshire Health Authority

Mrs Jackie Burns
(practice nurse/clinical member)
Practice Nurse
Barlow Medical Centre, Manchester

Mr Richard Matthews (primary care manager member)
Practice Manager
Rosedean Surgery, Cornwall

Ms Marcia Saunders (lay member)
Chair, Barnet Enfield and Haringey Health Authority

Dr William Reith (medical/clinical member)
General Practitioner
Westburn Medical Group, Aberdeen

Ms Julie Miller (support manager)
Investigations Manager
Commission for Health Improvement

Mrs Margaret Tozer, (lead manager)
Investigations Manager
Commission for Health Improvement

Miss Paula Wise
Administrator
Commission for Health Improvement

Documents reviewed by CHI

Advisor to the Team:

Dr M J B Wilkinson (GP prescribing advisor)
Member of Prescribing Committee for the
Royal College of General Practitioners

Professional advice:

Ms Liz Fradd
Director of Nursing
Commission for Health Improvement

Dr B Tennison
Primary Care Development Team
Commission for Health Improvement

Guidelines:

- UKCC Guidelines, e.g. *Practitioner- Client Relationship and the Prevention of Abuse*
- RCGP Guidelines, e.g. *Clinical Governance: Practical Advice for Primary Care in England and Wales*
- GMC Guidelines, e.g. *Seeking Patients' Consent: the Ethical Consideration, Intimate Examinations. Making and using visual and audio recordings of patients*
- RCN Guidelines, e.g. *Sexuality and Sexual Health and Nursing Practice*
- *Health and Social Care Act 2001*
- *Organisation with a Memory*. Report of an expert group on learning from adverse events in the NHS
- *Revalidating Doctors: Ensuring Standards, Securing the Future*. GMC
- *FHS Disciplinary Procedures*. A guide for health authorities, August 1996
- *GMC Performance Procedures EL (97)78 The management of doctors with problems*
- *Multi Research Ethics Committees. Declaration of Helsinki*, October 2000.
- Leicestershire County Council Advisory note to all employees, *How to raise issues which cause you serious concern*
- GPC Guidance. *A basic framework for medical partnership agreements*
- *Duties of a doctor registered with the GMC*

Leicestershire Health Authority (LHA) papers/reports

- Briefing paper for CHI. *Management and provision of primary care*
- Director of Public Health's reports for 1996/97, 1997/98, 1998/99 and 1999/2000
- Director of Public Health's letter to GMC and enclosures
- New disciplinary procedures in family health services, November 1996
- Framework for Public Partnerships, 6 October 1999
- Annual Report for 1996/97, 1997/98, 1998/99 and 1999/2000
- Primary Care Clinical Governance Baseline Assessment - C2 Report
- Process to respond to General Practitioners who give "cause for concern"
- Leicestershire Health Authority and Local Medical Committee: *Guidance on intimate examinations and chaperones, GPs and counselling, hypnosis, administration of midazolam in the primary care setting, making and using visual and audio recordings of consultations and research practice*
- Risk Management Strategy, 2 September 1998
- Quality Strategy
- Quality Committee, January 1999 and September 1998
- Annual Quality Report, 2 September 1998

- Organisation chart and paper on organisational change

- Leicestershire Primary Care Audit Group Annual Report - 1997/98

- Leicestershire Primary Care Audit Group Annual Report - 1998/99

Untoward Incident Reporting

- Serious Untoward Incident Reporting Protocol - Leicestershire, Non Leicestershire and Independent Sector Providers, Including Primary Care Independent Contractors
- GP practices serious untoward incident monitoring statistics April to June and July to September 2000
- Serious Untoward Incident Reports - Primary Care

Complaints Handling

- Complaints/enquiries - 1 April 1996 onwards
- Complaints procedure (version 9)
- Complaints procedure (version 8)
- Complaints procedure 1996
- November 1996, handling of complaints 1 April - 30 September
- NHS complaints procedure 1996/97 - lessons learned
- Lessons learned from complaints, November 1997
- Extract from LHA annual report 1997/98 - complaints report
- Extract from LHA annual report 1998/99 - complaints report
- Extract from LHA annual report 1999/2000 - complaints report

Performance Management Arrangements

- North Charnwood Primary Care Group (PCG) clinical governance concordat 2000/01

- North Charnwood PCG: clinical governance development plan 2000/01
- North Charnwood PCG: draft public interest disclosure act 1998
- North Charnwood PCG: Whistleblowing in the NHS
- Letter from Chief Executive to North Charnwood PCG Chairman about annual accountability agreement 2000/01
- North Charnwood PCG: annual accountability agreement 2000/01
- Performance management framework for PCGs
- North Charnwood PCG - mid year review 1999/2000

District Audit Reports

- District Audit Management Letter 1996/97
- District Audit Management Letter 1996/97
- District Audit Management Letter 1999/99

Practice Partnership

- Partnership history

Healthcall Details

- Healthcall monitoring arrangements

FHSA Complaints

- Extracts from LHA files about complaints handling by the former family health services Authority (FHSA)
- Statement regarding a meeting with a complainant and his employer
- Extracts from Leicestershire FPC Service Committee Minutes
- Department of Health's notes of guidance to the FPS complaints procedure
- 1990 FPC complaints correspondence

APPENDIX D

Alert Letters

- Alert letters to Trent NHS Chief Executives and Regional Directors of Public Health
- Letter to senior partners of all Leicestershire GP Practices from director of primary care and corporate services (LHA)
- Letters from Director of Primary Care and Corporate Services (LHA) to:
 1. Chief Executive of Lincolnshire Health
 2. Manager of Healthcall, Leicester
 3. Manager of Leicester West GP Co-operative Deputising Service

FHSA Personnel

- Former FHSA personnel and FPC personnel

Primary Care Group Documents

- Minutes for North Charnwood Board - September 2000 and January 2001
- Minutes of PCGs, July and September 1999

Additional Documents Requested/Received

- Statements by practice GPs
- Partnership Deed 16.12.88
- Appointment of trainers - formal visit reports 04.11.92, 28.07.93, 01.09.93, 28.11.95, 23.01.96
- Agreement of provisional re-approval for 3 years 25.01.96
- Report on a formal re-approval visit 11.05.99
- Correspondence relating to university approval and re-approval of the practice as GP trainers 07.06.99
- Confirmation of appointment as a general practice trainer 07.06.99
- Several practice meetings minutes
- Report concerning a counselling client, 10.06.97
- General practice assessment survey: North Charnwood PCG
- Regional criteria for training 2000

List of people interviewed

The team is grateful to the health authority's assistant director of corporate management and administrative staff for scheduling meetings for the week of 8 January 2001 and to Mr S Morrison of the Trent regional office for scheduling meetings on 6 February 2001.

Health Authority Staff

Baker, S Mrs, Consumer Services Manager
Blackler, C Mr, PCG General Manager (Formerly: General Manager, Director of Primary Care and Corporate Service LHA)
Blane, A Mr, Assistant Director - Corporate Management
Crump, B Dr, Director of Public Health
Froggatt, M W Mr, Chief Executive
Healey, G T M Mr, Chairman
McCargow, C Ms, Chief Nursing Advisor
McGarrity, C Dr, Medical Advisor
Orford, K Mr, Director of Finance
Partridge, P Mr, Lay Conciliator
Roper, V Mrs, Dental & Pharmaceutical Contracts Manager
Sursham, A C Miss, Secretary to the Authority
Thomas, S Mrs, Convenor
Virani, S Ms, Convenor

North Charnwood Primary Care Group Staff

Barrett, A Ms, Clinical Governance co-lead
Evans, K J Dr, PCG Chairman & LMC Secretary
Hanlon, G P Dr, Deputising Services Liaison Officer, LHA & clinical governance co-lead
Small, N Mr, General Manager & Community Services Manager Leicestershire & Rutland Healthcare Trust

Former FHSA & FPC Staff

Bates, P Mr, Chief Executive
Harding, A Miss, former Director of Corporate Management
Shapiro, J Dr, Health Services Management Centre, Birmingham

Department of Health

McKay, N Mr, Chief Operating Officer NHSE

NHS Executive Trent regional office

Dally, J Ms, Parliamentary Business Manager
Holliday, J Mr, Senior Primary Care Policy Manager
Holmes, T Ms, Head of Communications
Marchment, M Mr, Regional Director of Performance Management
Nicholson, D Mr, Regional Director
Salfield, N Mr, Deputy Director of Public Health
Shields, P Mr, Business Manager, Central Patch Team
Tutt, G Ms, Assistant Director

Practice Partners

Bagley, A M Dr, GP
Campbell, Dr, retired practice partner (telephone interviews)
Euden, M Dr, GP
Jewson, D G Dr, GP
Price, R J A Dr, GP
Veitch, Y Dr, GP

Current Practice Staff

12 secretarial/administrative staff
2 practice nurses
Practice manager

Former Practice Staff

4 secretarial/administrative staff
Practice manager

Leicestershire & Rutland Healthcare NHS Staff

Edgar, Dr, Medical Director
Hickling, W Mrs, Chairman
Murphy, M Mr, Director of Performance
Taylor, M Mr, Chief Executive
12 members of nursing staff (attached to practice)
3 former members of nursing staff (attached to practice)

Local Medical Committee

Crowe, M G F Dr, former Chairman
Evans, K J Dr, Secretary & PCG Chairman
St John, A F R Dr, Chairman

Community Health Council

Charlesworth, E Mr, Chairman
Smits, Z Mr, Deputy Chief Officer
Sturman, P Mr, Chief Officer

APPENDIX E

Public information sheet: How you can contribute to the Investigation

General Medical Council

Buckley, P Mr
Cotton, M Mr

Health Service Ombudsman's office

Scott, H Ms, Deputy Health Service
Ombudsman

Leicestershire County Council

Lincon, H Ms, Assistant Director Social
Services

Police

Abbott, D Officer
Chotak, P Officer
Holland, W Superintendant, Area
Commander
Hopkins, M Officer

POPAN

Blunden, F Ms, Director
Herring, J Ms, Coordinator

University of Loughborough

Williams, Clyde Professor (telephone
interview)

Patient and family project contacts

5 telephone interviews
3 face to face interviews
117 completed questionnaires

Stakeholders

11 telephone interviews
8 face to face interviews
13 enquiry forms
2 letters

Others

Posnett, John Dr, Chairman, National

Evaluation Working Party on Complaints
(telephone)

Hunter, Michael Dr,

Meppe, M Mr, Social Services Inspectorate
(telephone)

Stacey, T Professor, Director, Central Office
of Research Ethics Committee (telephone)

Introduction

You may have heard that the Commission for Health Improvement is undertaking an investigation in Loughborough. This information sheet has been written for people living and working in the area (including NHS staff and patients) to inform them about: the Commission for Health Improvement and why the investigation is taking place; how the investigating team will work; and how people may contact the investigating team.

The Commission for Health Improvement (CHI)

CHI is a new body, set up in April 2000, reporting directly to the Secretary of State for Health in England and the National Assembly in Wales. It has been set up to advise the NHS on improving the quality of patient care. CHI does this by investigating matters of public concern in the NHS, and it is for this reason that an investigation is taking place in Loughborough.

How the investigation will work

The investigating team will include a doctor, a nurse, a senior NHS manager, a practice manager, a lay representative and two investigation managers. CHI employs the investigation managers, but other team members are drawn from the NHS and community outside of the Leicestershire Health Authority area.

During the investigation, the team will arrange to meet medical, nursing and other staff to discuss patient services in primary care, that is services provided in general practice. The team will have background information about these services beforehand, for example, professional standards that staff work to, leaflets available for patients.

How people can talk to the investigating team

People will have an opportunity of talking to, or providing information to the investigating team by:

- * ■ Meeting the team by invitation. Medical and nursing staff and others involved in caring for patients, and patient representatives will be invited to meet the team and will be contacted directly. These meetings will take place in the week of 9th January 2001.
- Asking to meet members of the team in confidence at the Leicester Community

Health Council offices at 92 Regent Road, Leicester or a venue in Loughborough which will be confirmed when making appointments. Community health councils work independently to represent the public interest in the NHS. Further information is given below. Patients and members of the public will have their travel costs reimbursed.

- Completing the form attached to this information sheet and returning it to the free post address below by the end of December 2000.
- By writing to, or telephoning the investigation manager – name and telephone number below.

How we will report your views

The report will be sent to people meeting the investigating team, and on request. It will also be published on CHI's website www.chi.nhs.uk

How you can contact us

To make an appointment, to send comments, or to request more information please contact Margaret Tozer, investigation manager by:

- Post at: Commission for Health Improvement, FREEPOST, LON 15399, LONDON EC1B 1QW.
- Telephone on 0845 601 2238 (charged at local rate) – we offer a ring back service at your convenience.
- Fax on 020 7448 9222
- e-mail on Margaret.tozer@chi.nhs.uk
- By visiting our web site for background information at www.chi.nhs.uk

Making a complaint about NHS services

As stated earlier, CHI does not investigate individual complaints. While we are interested to hear your experience, you may obtain more information about making a complaint about the NHS from:

Ms Val Booth, Inquiries Officer
Leicestershire Health Authority
Leicestershire Health HQ Building

APPENDIX F

Protocol for obtaining patient and family views

Gwendolen Road
Leicester. LE5 4QF
Telephone number: 0116 2588678

Mr Philip Sturman
Chief Officer
Leicestershire Community Health Council
92 Regent Road
Leicester. LE1 7DA
Telephone number: 0116 2552517

Analysis of issues arising out of complaints review and meetings with the patients and public

Guiding principles

- 1) Recognising that for some patients and their families it will be painful to talk about the issue under investigation, the interviewees will be organised to make the meetings as comfortable as possible. Counselling support will be available after the meetings.
- 2) People attending the interviews may bring a friend or family member with them.
- 3) Investigating team members will conduct the interviews in a manner which maintains impartiality and enables accurate reporting.
- 4) Patients and their families will have an opportunity to express their views fully and frankly.
- 5) The investigating team will respect the confidentiality of individual points raised and not attribute them in the report, unless they are unable to report without doing so. In these circumstances, the express permission of individuals will be sought.
- 6) Investigating team members will use the information gathered from the questionnaires and interviews to identify lay concerns about NHS compliant systems, and use these to inform the findings of the investigating team.
- 3) All questionnaires will be allocated a reference number.
- 4) All questionnaires\letters received will be retained in a locked filing cabinet.
- 5) Every effort will be made to provide appointments for interviews at a time and location convenient to them.
- 6) All interviewees will receive an explanatory note about the format of the interview prior to the interviews taking place.
- 7) The analysis of the questionnaires and the interviews, will be totally anonymous and will be included in the report of the investigation.
- 8) All interviewees will be offered the opportunity of receiving a copy of the report of the investigation.

Reference Committee Members

Julie Miller

Investigations Manager, CHI

Dorothy Lloyd-Owen

Principle Adult Psychotherapist, The Portman Clinic

Tavistock & Portman Clinics NHS Trust

Marcia Saunders

CHI investigating team lay member and chair of the committee

Sarah Scobie

Senior Analyst, CHI

Philip Sturman

Chief Officer, Leicestershire Community Health Council

Kieran Sweeney

Medical Adviser to Primary Care Group Development Team, CHI

Margaret Tozer

Investigations Manager, CHI

Process

- 1) All incoming calls arising from the “dear patient” letter, or associated with the “dear patient” letter will be logged on the screening form – one for each enquirer – and record who dealt with the enquiry.
- 2) All enquiries left on the answer phone arising from the “dear patient” letter, or associated with the “dear patient” letter will be logged on the screening form – one for each enquirer – and record who has dealt with the enquiry.

Introduction

1. Our analysis comprises:

- A review of a random selection of FHSA and health authority complaint files
- Contact with patients and the public affected by the events which triggered the CHI investigation

Review of complaints

2. As part of the investigation, CHI reviewed a random selection of complaint files: 1992/93 (FHSA), 1996/97 (when the new NHS complaints procedure was introduced) and 1999/00. These files related to all complaints received by the health authority, not just those relating to primary care, since they are not filed separately.

3. From the files reviewed for 1992/93 the majority of letters to patients in response to concerns about the NHS from the FHSA senior liaison officer were helpful and offered appropriate advice.

4. We noted that a patient contact form was introduced in 1996. Health authority staff, following each telephone contact with a member of the public, complete one of these forms. Some inconsistencies were noted but the level of information provided to enquirers by the health authority was generally good. Response letters to patients advising them of the practice based complaints procedure were clear and helpful, although there was an inconsistency in that the original letter was not always returned to the enquirer for them to contact the practice direct. On these occasions a standard response letter was used which was informative.

5. CHI found no evidence of a mechanism to follow up action taken as a result of complaints, either by the patient or the practice. Thus it was difficult to determine how lessons from complaints could be learnt.

6. Three independent review (IR) files were scrutinised for 1996/97. All were processed within adequate timeframes and responses written in user-friendly language. In two cases it was evident that steps had been taken by the health authority to notify the clinicians concerned of the IR recommendations, but the team found no evidence that this was monitored further. In

the other case, it was unclear whether follow up had taken place.

7. The most recent complaint files reviewed (1999/00) demonstrated that the completion of the patient contact form was more thorough and consistent. The tone of letters to patients from the health authority continued to be courteous and informative. There was some evidence of inconsistency however, in the information given to complainants. For example, information on how to proceed if the patient remained dissatisfied following local resolution was not always given. Not all letters refer to the role of the lay conciliator, which is unfortunate since this facility appears to work well and is available authority wide. The community health council confirmed this perception.

8. Two IR files for 1999/00 were also reviewed and both had been processed within adequate timeframes. However we found no evidence to suggest follow up or monitoring of outcomes. Recommendation 5.8 should ensure more appropriate follow up and monitoring.

Contact with stakeholders, patients and the public

9. Contact with patients and the public was integral to the investigation. Two approaches were used.

10. Meetings and telephone interviews were held with stakeholders to:

- understand better issues about the quality of the services in the context of local health services
- inform discussions in the week of the formal investigation
- publicise the work of the investigation openly and positively

By stakeholders we mean people living and working in the area who were not part of the formal investigation but who have an interest in the local NHS. People were also invited, if they preferred, to write to CHI or to return a simple proforma.

11. Additionally, all patients who were registered with Peter Green were contacted and invited to complete a questionnaire or to meet CHI. The purpose was to:

- review with interviewees procedures to

support patients who wish to speak up about problems they perceive with aspects of their treatment and care, or to make a formal complaint, including attitudes towards, and communication with, patients

- seek views on what the NHS can learn about improving methods for raising comments and concerns
- develop proposals in consultation with interviewees for improved procedures and the way in which those procedures will be monitored

12. Contact with stakeholders can be categorised as:

- 8 face-to-face interviews
- 11 telephone contacts/interviews (some of these telephoned more than once)
- 13 returned enquiry forms
- 2 letters

13. Contact with patients and families directly affected by events can be categorised as:

- 3 face-to-face interviews
- 5 telephone contacts/interviews (some of these telephoned more than once)
- 117 returned questionnaires
- 3 e-mails

14. Several people returning the questionnaire commented that they had always been very happy with their treatment and care and with Peter Green. The purpose of the investigation however was not to review the clinical practice of Peter Green, or his colleagues. We also received comments on access to services, for example, access for people with disabilities, availability of therapies for children, transport issues. These comments will be made available, with the consent of those contacting CHI, to the review manager when CHI undertakes a clinical governance review in Leicestershire.

15. Key points made by people directly affected by the events and speaking to CHI included:

- i. a very intimidating experience and no acknowledgement or understanding of the allegations
- ii. as the scale of the issues and the legal implications grew, lack of support before and during trial and a lack of understanding of how information provided to the police would be used
- iii. people abused in the NHS should have confidence in the openness and professionalism of staff in order to make a complaint – avoid feelings of closing ranks
- iv. feelings of embarrassment and a lack of confidence coupled with a belief that the complaint would fall on deaf ears
- v. only when individuals are accountable professionally and financially will things change
- vi. no one seemed to question the length of appointment times
- vii. how was it possible for someone else to be in the consulting room without the patient's consent
- viii. public inquiry needed to establish if there were other abusers and to shame those that ignored the victims
- ix. Peter Green kept his own notes in a box file – patient held/electronic records should help with falsification issues.
- x. practical help needed, for example accessing medical records, resources to meet survivors needs

Glossary

- xi. difficult for people to leave their name and telephone number on an answer machine when not sure to whom disclosing information
- xii. a nurse should be present during intimate examinations
- 16. In response to questions about the NHS complaints procedure, people felt that:
 - i. clarity about complaints process and timescales so that people know what to expect, to include a leaflet which explains options and supporting publicity, for example posters
 - ii. access to sympathetic and confidential advice essential
 - iii. complaints system must be structured and allow for commitment to enable concerns to be addressed
 - iv. important that concerns are dealt with objectively

- v. important that people kept informed about progress of complaint
 - vi. confidence is needed that there will be no repercussions
 - vii. proper analysis of the issues raised and follow up action through staff training where this is needed
 - viii. an electronic system is needed to record and monitor complaints
 - ix. need a system where concerns, rather than complaints can be discussed objectively - whistle blowing polices may help
17. Recommendations 5.8, 5.12, 5.14, 5.15, 5.16 and 5.21 seek to address these concerns.

Accountability	Responsibility, in the sense of being called to account for something
Adverse incident	Something that has happened that is out of the ordinary and unintended which may be harmful to patients. (For example a patient falling on icy path, or on a slippery floor in hospital)
Advocacy	A scheme which represents vulnerable patients. An advocate is a person unrelated to a patient who can speak on their behalf and make a case for their welfare.
Alert letter	Issued by the NHS Executive to inform NHS organisations about potential problems with specific doctors
Anaesthetics	The study and practice of a branch of medicine that controls a patient's consciousness during an operation. It may also deal with intensive care and pain control.
Appraisal	An assessment or estimate of the worth, value or quality of a person or service or thing
Audit	A review that establishes how well a service meets pre-determined standards or criteria
Blue print process	Organisational audit tool developed in Leicestershire for general practice to work towards achievement of ten quality standards. Assessment is by external peer review, there is a pass /defer/fail element and all ten standards have to be achieved to pass.
Child health surveillance	Routine screening for children to monitor health and physical development
Clinical	Clinical means any treatment provided by a healthcare professional. This will include, doctors, nurses, therapists etc. Non-clinical is administration, catering, portering etc
Clinical audit	The continual evaluation and measurement by health professionals of the clinical standards they are achieving
Clinical governance	Refers to the quality of healthcare offered within an organisation. The DoH document " <i>A First Class Service</i> " defines clinical governance as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. It's about making sure that health services provide patients with high quality and high standards of care.
Clinician / clinical staff	A fully trained health professional – doctor, nurse, therapist, technician etc.
Commission for Health Improvement (CHI)	Independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.
Community health council (CH)	A statutory body sometimes referred to as the "patients' friend". CHCs represent the public interest in the NHS and have a right to be consulted on health service changes in their area.
Consent	Permission to allow a health treatment or investigation to happen. Sometimes a carer will be asked to sign a consent form if the patient is too ill.
Convenor	A person, usually a non-executive director, chosen by the

	health authority or trust to manage complaints
Drugs - controlled	Controlled drugs are those whose use is restricted (by an act of law) to be given in certain circumstances and by certain groups of health professionals
Family health services	Those given by GPs and their teams
Family Practitioner Committee	The administrative and planning body for general medical services between 1974 and 1990 directly accountable to the secretary of state for its functions
General Practitioner	Your family doctor
GMC	The General Medical Council, the professional body for medical doctors which licenses them to practice.
General Medical Services	Services provided by general practitioners
Health authority (HA)	Statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities..
Health Service Ombudsman	Investigates complaints about failures in NHS hospitals or community health services, about care and treatment, and about local NHS family doctor, dental, pharmacy or optical services. Anyone may refer a complaint but normally only if a full investigation through the NHS complaints system has been carried out first.
Health visitor	A qualified nurse with extra training who works in the community primarily with parents and young children.
Independent review	This is stage two of the formal NHS complaints procedure. It consists of a panel, usually with three members, who look at the issues surrounding a complaint.
Independent review panel	The panel of people chosen to run the review (see independent review)
Independent contractors	As independent contractors, GPs work to a national contract to provide general medical service to NHS registered patients.
Investigation - by CHI	An in-depth examination of an organisation where a serious problem has been identified.
Investors in People	Investors in People is a national quality standard which sets a level of good practice for improving an organisation's performance through its people
Kings Fund accreditation	This is a process by which health services are audited for quality. It is no longer run by the King's Fund but by an independent non-profit charity called Health Quality Service.
Local medical committee	A committee elected by GPs which has a statutory role in that the health authority is required to consult the local medical committee on a wide variety of general medical service issues, including those relating to the provision of health care
Local research ethics	Local research ethics committees consider and approve research