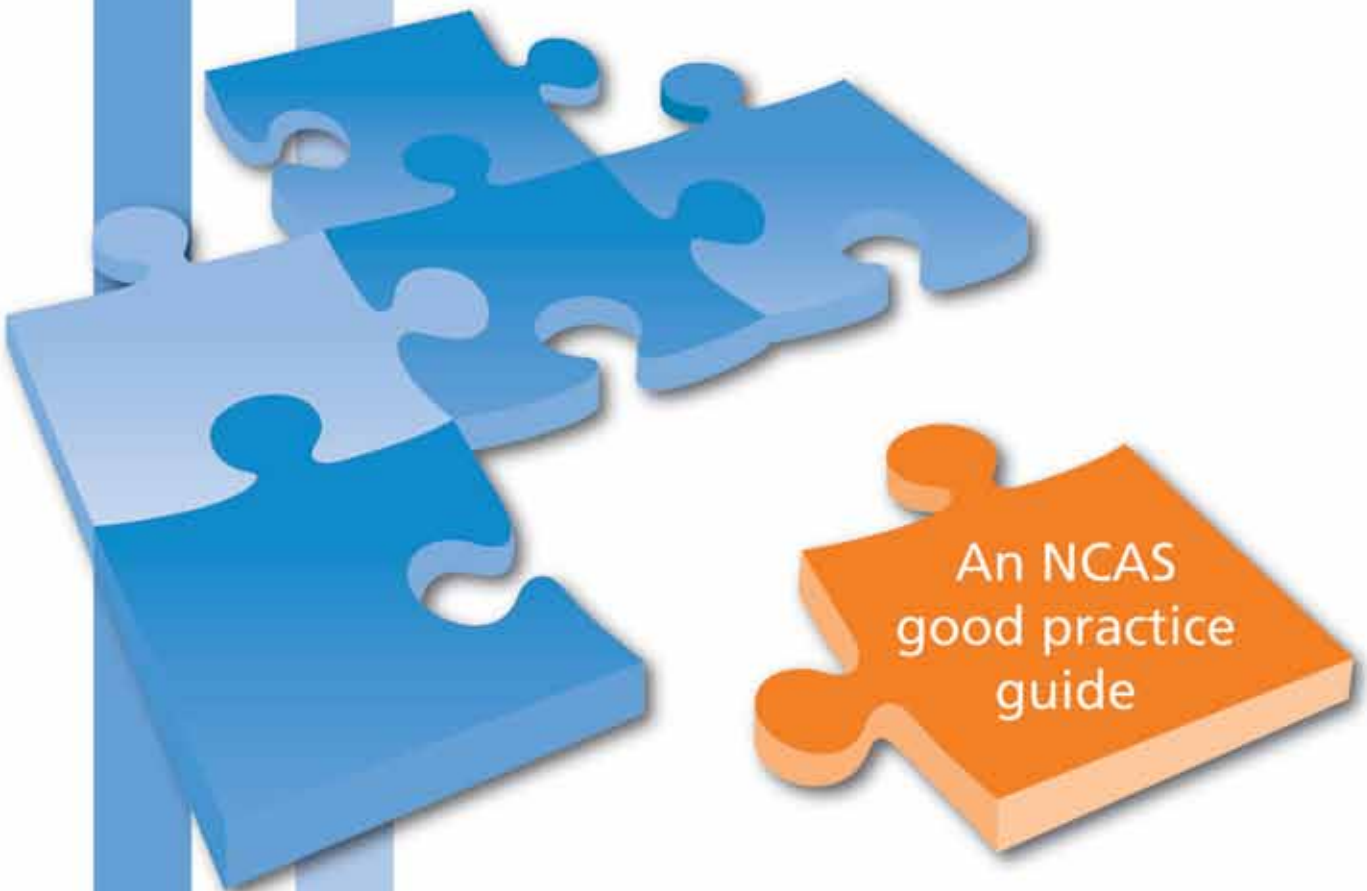
NHS
National Patient Safety Agency
National Clinical Assessment Service

How to conduct a local performance investigation



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Introduction

Purpose

The National Clinical Assessment Service (NCAS) is often asked for advice about local investigations into practitioner performance or conduct. While there are no firm rules about when to investigate or how, as each case has to be considered in relation to its own facts and circumstances, there are principles which can be followed in all sectors of healthcare and for any healthcare profession.

Identifying and dealing with performance problems promptly and efficiently can reduce potential risk for patients, practitioners and the teams they work in, as well as for the service as a whole. This guide suggests what this might mean for investigations. It follows the sequence of an investigation from first notification of a concern to the point at which findings are made available to decision-makers. It is written for both primary care organisations (PCOs) and organisations providing hospital and community (H&C) services, in both the NHS and independent sectors of healthcare.

Assumptions

As part of its governance programme, every organisation should have performance procedures which are objective, fair, up-to-date and easily accessed by anyone interested in them. Formal procedures should comply with core legislation and guidance. Organisations should aim to have managers trained to use the procedures and people identified as potential investigators and case managers so that investigations can proceed promptly, when needed. By assuming that local procedures and processes are in good order, this guidance can focus specifically on the investigating process. Other NCAS publications and guidance can be used to review local processes, if necessary, and managers can also ask NCAS advisers for help.

We have also assumed an understanding that guidance of this sort can cover only general principles and that the handling of a specific case must depend on the unique facts of that case. Where template formats are shown, these are illustrations of the types of issues and actions to consider; organisations should take legal advice, where necessary.

Relationship with other NCAS guidance

This guidance is written to be used alongside other NCAS publications including *Handling performance concerns in primary care* (2010). We have built on earlier NCAS guidance in *Local GP Performance Procedures* (2007) (now replaced by *Handling performance concerns in primary care*) and also on the joint Department of Health and NCAS publication *Handling Concerns About The Performance of Healthcare Professionals: Principles of Good Practice* (2006).

Further NCAS guidance can be downloaded from: www.ncas.npsa.nhs/toolkit

For current NCAS publications go to: www.ncas.npsa.nhs.uk/resources/publications/key-publications

Terms

'Organisation': a healthcare organisation employing or contracting with health practitioners.

'Investigation': an inquiry carried out by a healthcare organisation into whether or not there is a problem to address in a practitioner's performance.

'Practitioners': dentists, doctors and pharmacists, the groups within NCAS' current remit, although organisations may find the guidance useful in other contexts as well.

'Performance concerns': any aspects of a practitioner's performance or conduct which:

- pose a threat or potential threat to patient safety;
- expose services to financial or other substantial risk;
- undermine the reputation or efficiency of services in some significant way;
- are outside acceptable practice guidelines and standards.

A glossary of other terms can be found on page 23.

Legal framework

Statutory Instruments ('regulations') and frameworks differ from country to country and across the professions, so it is important to access the relevant legislation and guidance. The 'Must knows' sections on the NCAS website provide quick links to key NHS legislation in each country and for each practitioner group.
See www.ncas.npsa.nhs.uk/mustknows

Feedback

Feedback about this document would be greatly valued. Please send it to: ncas@ncas.npsa.nhs.uk

This is a guidance document but NCAS can be contacted at any stage for advice about the handling of specific cases.

1. Deciding whether to investigate

Performance concerns can come to light in many ways, including routine monitoring of management information, reports from patients and colleagues, appraisal, reports on serious untoward incidents and anonymous complaints or concerns. Anonymous reports may be difficult to verify but should not be dismissed. It is unlikely that on their own they would support formal action, but they may lend support to other evidence.

Any performance concern raises the possibility of a need for further investigation. This section outlines how to decide whether to conduct an investigation, by asking:

- **What is a performance investigation?**
- **How might concerns be screened for investigation?**
- **What should be considered in making a decision to investigate?**
- **What are the alternatives?**
- **When is an investigation likely to be appropriate?**

1.1 What is a performance investigation?

The purpose of a performance investigation is to determine whether or not there is a performance problem requiring action. A performance investigation is not a free-ranging inquiry. It is normally helpful to define the purpose of the investigation using terms of reference.

Terms of reference have to be determined based on what is known at the time an investigation is set up. If, later, a substantial issue comes to light that is outside the initial terms of reference, the terms can be reviewed and, if necessary, changed to ensure that the investigation covers the new issue.

An investigation report then sets out findings and the evidence on which the findings are based. The report informs a decision on whether to take action on the concern and how. It does not make the decision.

A decision to investigate commits the organisation to significant work and expense, so the organisation needs to be sure that a concern is serious enough to warrant an investigation, based on a review of available information.

1.2 How might concerns be screened for investigation?

Regardless of how a concern is identified, it should go through a screening process to identify whether an investigation is needed. Anonymous complaints and concerns based on 'soft' information should be put through the same screening process as other concerns.

The form that screening takes will vary from organisation to organisation. The essential requirement is that a consistent process is followed, with decisions made by a person or group with appropriate authority. Decisions made should be appropriately recorded and the practitioner kept informed of progress.

In *Handling performance concerns in primary care*, NCAS suggests the use of a decision-making group (DMG) supported by a professional advisory group (PAG), with membership suggestions made for both groups. In a primary care organisation (PCO) using this structure the DMG would usually make the decision to commission a local investigation or to take some other action such as referral to the police or counter fraud agency.
In secondary care, it is the designated responsible manager (often the medical director or deputy) who will determine (in consultation with others, as appropriate) whether or not an investigation is required. In both sectors, the interface with responsible officers for medical practitioners (once appointed) will need to be considered.

The purpose of screening is to identify whether there are *prima facie* grounds for an investigation and, if there are, to set terms of reference which are sufficiently detailed for the investigation to proceed. It is essential that managers set aside dedicated time to progress initial screening so that it can be completed properly and quickly.

1.3 What should be considered in making a decision to investigate?

Before deciding whether a performance investigation is necessary, consider what other relevant information is available. This could include:

- clinical or administrative records;
- serious untoward incident reports or complaints;
- earlier statements or interviews with people with first-hand knowledge of the concern;
- clinical audit and clinical governance data;
- the views of appropriate professional advisers;
- earlier occupational health reports.

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself.

There will normally need to be input from the practitioner too. As a general principle, NCAS encourages employers and contracting bodies to be transparent and to communicate and engage early with the practitioner whose performance is causing concern. NCAS suggests that the case manager or other appropriate person should have a preliminary meeting with the practitioner, explain the situation and what might happen next, and explain that they will be available to answer questions if the case progresses. The practitioner's initial comments can be taken into account in evaluating what further action should be taken. The practitioner should be offered the opportunity to be accompanied by a colleague or a union or defence society representative. A note should be taken and copied to the practitioner as a record of discussions and any case handling decisions.

Exceptionally, contact with the practitioner may have to be deferred if a counter fraud agency or the police advise that early meetings or early disclosure could compromise subsequent investigations. But generally, the practitioner's response will be helpful in deciding whether to carry out an investigation.

1.4 What are the alternatives?

Investigation should be judged unnecessary where:

- the reported concerns do not have a substantial basis or are comprehensively refuted by other available evidence;
- there are clear and reasonable grounds to believe that the reported concerns are frivolous, malicious or vexatious. While very few complaints fall into this category it is important that those that are not genuine are identified as soon as possible to avoid distress to the practitioner and waste of the organisation's time.

Even where there is evidence of concern, the decision may still be to dispense with investigation under the following circumstances:

- The practitioner may agree that the concerns are well-founded and agree to cooperate with required further action. However, if the issues raised are serious enough to suggest that if upheld they might warrant consideration of termination of employment or removal from a performers list, then the organisation may still need to conduct an investigation. The action to be taken subsequently would then be decided in the normal manner.

- Confirmed or suspected ill-health is another situation where performance investigation could be inappropriate. But health problems may be part of a more complex presentation where an investigation could still be helpful, so ill-health does not, by itself, rule out investigation. Information on a practitioner's health problems should remain confidential unless there are exceptional circumstances that require disclosure in the public interest.
- An investigation may also be judged unnecessary if the concerns are being investigated by another agency. An external investigation does not automatically preclude an NHS investigation but the organisation should have reasons for carrying out its own investigation into different aspects of potentially the same concern. There should then be close liaison with the other agency to avoid one investigation being compromised by the other.

The decision to proceed or not proceed with an investigation should be documented, with reasons, along with decisions on any alternative actions decided on. Box 1 shows what a meeting note might look like for a meeting where the decision is to defer investigation for the time being and take action straight away.

Box 1 – Recording a decision not to investigate, in primary care

This note sets out who decided what and why, and what has to happen next and when, with the note signed as a correct record by the chair. Similar records should be kept by the responsible manager in secondary care, showing the advice taken and the decisions made.

Note of meeting to consider whether to carry out an investigation into the performance of [practitioner] held on [date]

PRESENT: [ ]

[Member] said that he knew [practitioner] through common membership of the local representative committee but he did not believe there was a conflict of interest. It was agreed that [member] should continue to take a full part in the proceedings.

The circumstances of the concern were then summarised by [the responsible manager]. The following information had come to the [organisation]'s attention, suggesting that [practitioner] might be performing below an acceptable standard in relation to [specified aspects of care]:

- Information from patients/carers [summarised, anonymised].
- Information from management monitoring sources [summarised].
- Information from colleagues/staff [summarised, anonymised].
- Other information [summarised, anonymised].

[Responsible manager] advised that there were no immediate reasons for thinking that patient safety was at risk. Also, [practitioner] was aware of the organisation's concerns and had indicated a willingness to undergo a remedial training programme on [aspect of care].

Remedial training arrangements have still to be established with [the postgraduate deanery] but similar measures have been used successfully in similar cases of performance concern within the organisation

It was agreed that:

1. The concerns are already clearly enough understood for action to be taken.
2. Provided remedial training can be put in place, further investigation is unnecessary at this time. This will be taken forward by [the responsible manager] working with [ ].
3. The case should be reviewed after [ ] months.
4. No immediate action is needed to protect patient safety.

Signed as a correct record by [Chair]

Date

1.5 When is an investigation likely to be appropriate?

Investigation will usually be appropriate where case information gathered to date suggests that the practitioner may:

- pose a threat or potential threat to patient safety;
- expose services to financial or other substantial risk;
- undermine the reputation or efficiency of services in some significant way;
- work outside acceptable practice guidelines and standards.

In these situations, a well-undertaken investigation and report will probably help to clarify any action needed.

In deciding to go ahead with an investigation the screeners and decision-makers should have a clear view on the areas of performance that are a concern – what is to be included and what is to be excluded. The decision-makers might not draft the terms of reference but they should approve them before the investigation starts. The terms of reference should also set report expectations and timescales.

The process of deciding whether to hold an investigation is summarised in Box 2.

Box 2 – Checklist for deciding whether to investigate

	Responsibility	Date
Concern identified and referred to responsible manager	Anyone	
Practitioner normally notified of concern	Responsible manager	
Written confirmation to practitioner	Responsible manager	
First meeting with practitioner	Responsible manager	
Meeting date agreed for decision-making group (if applicable)	Responsible manager	
Additional information assembled	Responsible manager	
Decision made on whether to investigate	Responsible manager or decision-making group	

2. Protecting and supporting

Chapter 1 ended with the decision to investigate. Before the investigation can proceed, even to the planning stage, certain protections must be considered for the people who will be involved in the investigation in any capacity. A formal investigation of practitioner performance is likely to impact on patients, carers, other healthcare workers, the practitioner's staff and colleagues, expert and other witnesses, not to mention the managers carrying out the investigation. Each needs some level of protection or support while the investigation is under way. Organisations should, as appropriate:

- **protect patients from harm;**
- **protect people raising concerns;**
- **keep patients informed;**
- **support the practitioner;**
- **protect the organisation.**

2.1 Protect patients from harm

Depending on the facts of a particular case it may be necessary to consider formal suspension (in primary care) or exclusion (in secondary care). Where possible, discuss such cases with NCAS before taking action. NCAS provides a 24-hour, seven day a week service to deal with situations of this sort. Specific procedures must be followed to ensure that a suspension or exclusion is lawful.

Suspension or exclusion should only be used where there is no reasonable alternative. These measures are often described as 'neutral' acts intended to protect patients, staff and the practitioner, and not to be disciplinary sanctions. In practice, the practitioner – and possibly colleagues – may see them differently. While exclusion or suspension do protect patients, they can make performance improvement more difficult.

As alternatives, an organisation might:

- ask the practitioner to withdraw voluntarily from carrying out certain duties;
- offer suitable alternative NHS work away from direct patient contact, whilst investigations continue.

Voluntary agreements should be put in writing. They should only be used as an alternative to formal action if detailed, clear and robust enough to give the same certainty of protection as formal action. A voluntary agreement could also state explicitly that the practitioner is entering into a formal undertaking which, if breached later, might lead to referral of the practitioner to the professional regulator. For non-contractor pharmacists, voluntary agreements remain the only available mechanism to restrict their practice.

Discussion with NCAS is advisable before use of a voluntary agreement to restrict practice. The practitioner should be advised to consult a defence society, union or solicitor before signing. Voluntary agreements are not appropriate where there are significant health difficulties or dishonesty is suspected. Apart from anything else, they may compromise an organisation's ability to take a formal position later that the practitioner was not fit to practise. Any information related to a practitioner's health or personal circumstances should normally remain confidential.

For the legal frameworks governing suspension and exclusion in each country go to www.ncas.npsa.nhs.uk/mustknows. Local guidance, regulations and ministerial directions (for example in England, *Maintaining High Professional Standards in the Modern NHS* (MHPS), Department of Health 2003) specify how practitioners must be notified that suspension or exclusion is being considered and given opportunity to make any representations.

For an outline voluntary undertaking to restrict practice, see Box 3.

Box 3 – Voluntary restriction of practice

Dear [Practitioner]

I am writing to confirm your undertaking today that with immediate effect and until further notice you will not provide any form of care to [specified patients], either at [normal workplace address] or at any other workplace.

You accepted that this is a formal undertaking and that if you breach the undertaking it would constitute professional misconduct and it would be appropriate for [organisation] to refer the breach to [professional regulator].

You will now have had opportunity to discuss this undertaking with your [defence society]. If you are still in agreement please confirm this by sending me the enclosed copy of this letter, signed and dated. If we do not receive this by [date] we will take formal action to protect patients.

Your undertaking will remain in force until our current investigation is complete. We will review it as part of the process of deciding the action to be taken (if any) in the light of the investigation's findings.

Yours sincerely

[Manager]

In situations such as this, the organisation may also need to consider whether to inform the relevant professional regulator. Regulators are concerned with issues that raise questions about a practitioner's fitness to practise. In its initial consideration of a case the healthcare organisation has a number of options, including referral to the regulator and other agencies. If it has been decided that a local performance investigation alone is required and, providing patient safety is assured, then there will be no reason to notify the regulator unless or until local proceedings identify serious concerns which bring into question the practitioner's capacity to practise at all. If in doubt, discuss the options with NCAS.

Where a practitioner giving cause for concern has resigned or been dismissed by the employer or is otherwise unavailable, the organisation may still decide to carry out an investigation to learn from the episode and, if possible, prevent it happening again. Where a practitioner moves away before performance concerns have been resolved, and is thought to pose a significant risk if re-employed elsewhere, organisations can also consider the issue of an alert notice. See www.ncas.npsa.nhs.uk/toolkit/disciplining/consider-who-else-needs-to-know for more advice on use of alert notices. Once issued, alert notices must be kept under review and rescinded as soon as they cease to be applicable. Alert notices are not issued in Scotland.

2.2 Protect people raising concerns

Whistleblowers and other people raising concerns about professional colleagues may feel vulnerable, particularly if still working with the practitioner concerned. As long as their concern is genuine, they should be protected by the organisation's local policy on whistleblowing and, where applicable, the *Public Interest Disclosure Act 1998* (PIDA). The organisation's human resources team could offer advice on the Act's provisions. Advice for individuals could also come from local representative committees, union or defence society advisers, or from professional regulators. The charity, Public Concern at Work (www.pcaw.co.uk) also offers confidential advice which can be accessed by people not employed by the organisation and therefore not covered by PIDA.

In practice, it is not usually possible to protect the identity of reporting practitioners, especially within small teams. Practitioners with potential performance concerns are likely to ask questions and try to guess the name of informant(s). They may make counter-allegations which will put working relationships under strain. Explaining the situation and the organisation's investigative procedures to both parties can help formalise the position and

prevent discussion within the team. Remind the practitioner and others involved in the investigation to avoid any action which could be seen as attempting to influence witnesses or influence the investigation in other ways.

Managers should recognise the stress that the practitioner may be under. At the same time, they must try to protect those around from further stress. If it becomes difficult for a team to continue functioning effectively then suspension or exclusion from work may have to be used, either against the practitioner whose performance is a concern or against another practitioner who is not treating the investigated practitioner reasonably.

Where witnesses ask to provide information anonymously, the investigator needs to strike a balance between the rights of the practitioner under investigation and the need to collect evidence. There are some circumstances where it may be possible to proceed even if the practitioner is not informed of the identity of witnesses. The important need is for the practitioner to know the evidence against them and the case they have to answer.

The courts have held anonymity to be reasonable in cases involving sexual misconduct or where there is a real or perceived risk of harm to the informant. In these circumstances the investigator should take a full statement from the witness and then anonymise it by erasing the parts which could identify the witness.

In other cases the investigator should explain why anonymous allegations are undesirable. So long as the concerns are genuine, the informant ought to be protected by any local policy on whistleblowing and, where applicable, by the provisions of PIDA.

When anonymous information is taken into account it is good practice for the investigator to record the issues considered and the reasons for allowing the informant to remain anonymous. The investigator should be available at any subsequent hearing to be cross-examined on the anonymous evidence and the reasons for anonymity.

2.3 Keep patients informed

Patients who are already aware of a concern (as complainants, for example) should normally receive the information provided for by the organisation's complaints handling procedure about the actions being taken and relevant timescales. Depending on the circumstances, it may be appropriate to brief patients more actively.

It would not be usual to release information about an ongoing investigation more widely to patients, unless some form of public announcement is necessary – in the event of a look-back exercise, for example. It would then be good practice to discuss a proposed information release with the practitioner first.

Information about a look-back will depend on the facts of the case. Whether a look-back exercise is necessary should be discussed with appropriate experts, for example in the relevant royal college or the Health Protection Agency. Patients whose care has to be reviewed should be contacted with an explanation of the medical need for the review and its implications. A contact point should be identified for further information. Where possible, a review exercise should not identify the practitioner concerned.

Media enquiries will usually go to named individuals within the organisation who have been trained and authorised to respond to them. The information provided to the media should not differ from the information which might have been given to individual patients. Care must be taken to preserve the confidentiality of patients and, where possible, the confidentiality of the practitioner.

The organisation will probably have local policies on media handling and on access to internal communications advice. Depending on the sensitivity of the issues, it could be appropriate to take external advice as well, to ensure that any information about the investigation reaches the media in the most appropriate way. Where possible, any information to be given to the media should be discussed with the practitioner in advance and the practitioner should have an opportunity to discuss the proposed statement with a union or defence society representative.

2.4 Support the practitioner

The practitioner was probably already told that an investigation might take place (see section 1.3). Once the decision to investigate has been taken, there should normally be another meeting, organised in the same way, with the practitioner offered the opportunity to be accompanied, and with a note of the meeting kept.

The meeting can, as appropriate, explain and allow questions about:

- Terms of reference, timescale, names of case manager(s) and investigator(s) and the process which the practitioner can use to respond to the concerns raised.
- The regulations and local procedures governing the case's handling. In England, for example, MHPS contains detailed guidance on investigation procedures while the Performers List Regulations do not specify how investigations should be conducted. The organisation therefore needs to be clear to the practitioner about which procedures it is applying.
- The reasons for any restrictions on practice or suspension/exclusion, with explanation of the potential consequences if requirements are not complied with. The relevant regulations set out notification requirements – see www.ncas.npsa.nhs.uk/mustknows
- Any proposed statements to patients, colleagues or the media, with the practitioner given enough time to discuss them with advisers/representatives. Ordinarily, colleagues would not have a direct need to know why the practitioner is under investigation or why they have been suspended or excluded from work. But some limited release of information may be appropriate and it is better if this can be agreed with the practitioner.
- The need for the practitioner not to attempt to influence potential witnesses – the same instruction going to everyone else involved in the investigation.
- Personal support mechanisms.

Being the subject of an investigation is likely to be very stressful for the practitioner. Support mechanisms could include access to occupational health services and professional psychological support or counselling. Managers should use occupational health services for advice on fitness to work or related questions about the practitioner's health. When making a referral to an occupational health physician, be explicit about the health issues which are causing concern. Use of GP or other routes does not prevent the occupational health physician giving advice on fitness for work, if necessary, provided there was a manager referral in the first place. If the practitioner self-refers to the occupational health service, the manager will not necessarily receive feedback.

Remember, when conducting an investigation, that it is likely the practitioner will continue working for the organisation afterwards so it is important to try to maintain an effective relationship throughout the process.

2.5 Protect the organisation

Keep in mind what could happen next and the need not to put investigators and decision-makers in positions where they might appear later not to be acting impartially, putting the organisation's actions at risk of challenge:

- People who might be involved in subsequent disciplinary proceedings or appeals should not be part of a decision to investigate or an investigation.
- People carrying out investigations should not be involved in later decisions to take formal action against a practitioner based on the investigation's findings.
- The position of the chief executive (CEO) should not be compromised. The responsible manager will need to report a serious concern to the CEO as the accountable officer, as soon as it is known about. But if local procedures mean that the CEO is likely to participate in subsequent formal decision-making processes (such as consideration of list removal or exclusion/suspension), the CEO should only be told the broad nature of the concerns.
- Sometimes a practitioner whose performance is causing concern may complain of bullying or harassment. Such complaints should be investigated in accordance with local policies, but overseen by a manager who is not otherwise involved in handling the concern.

3. Managing the investigation

The investigation starts once its terms of reference are finalised and when a case manager and investigator(s) have been appointed. Once the decision is taken to hold an investigation there should normally be discussion with the practitioner to secure as much engagement as possible. The practitioner should be made aware of the terms of reference and who the proposed case manager and investigator(s) are so that any objections can be raised.

The organisation can then:

- **finalise terms of reference;**
- **appoint a case manager;**
- **appoint case investigator(s).**

The investigator(s) will:

- **collect evidence;**
- **interview the practitioner;**
- **weigh the evidence and identify the facts of the case.**

3.1 Finalise terms of reference

These will have been agreed in outline at the time a decision was made to carry out the investigation, but some final drafting may be needed. The terms of reference as finally drafted should be agreed by the organisation's relevant decision-maker(s). The case manager and investigator(s) appointed to manage and carry out the investigation (see next sections) would not normally be involved in this process.

Terms of reference should be tight enough to prevent an unfocused general investigation of everything concerning the practitioner. It may be appropriate to specify areas not to be investigated as well as the areas where evidence and commentary are expected. Box 4 suggests a format.

Box 4 – Terms of reference for an investigation

An investigation is commissioned into the performance of [practitioner's name], working as a [practitioner's job title] for [organisation's name], at [workplace address].

The matters to be investigated are [ ].

The following matters are excluded from the investigation [ ].

It is expected that the investigation will be completed by [date] and that a report will be submitted to [named manager] by [date].

The report should detail the investigation's findings of fact and include a commentary on how the performance of [practitioner's name] compares with that expected from a practitioner working in similar circumstances.

As a minimum, terms of reference should set out:

- the issues to be investigated;
- the period under investigation;
- the timescale for completion.

It may be that as the investigation progresses the terms of reference are found to be too narrow or that new issues emerge that warrant further investigation. In such cases, the investigator(s) should inform the case manager who should seek the agreement of the responsible manager or DMG to a widening of the terms. Such requests should be decided on promptly so that the investigation is not delayed. The practitioner must be informed of any changes to the terms of reference unless, exceptionally, he is kept unaware of the investigation at all.

3.2 Appoint a case manager

A case manager is normally appointed by the DMG (in primary care) or the responsible manager (in the H&C sector). Usual practice is for a case manager to be a senior member of the organisation's staff, with a role to:

- ensure that the investigation is conducted efficiently;
- ensure that confidentiality is maintained where appropriate;
- act as the coordinator between investigators, the practitioner and anyone who the investigators need to interview;
- obtain any documentation required;
- ensure that the process is properly documented;
- receive the investigator's report;
- make recommendations to the responsible manager or the DMG on what action might follow, having regard to the contents of the investigator's report.

To be seen to be objective, case managers need to be able to demonstrate that they:

- understand the general nature of the concerns raised and the clinical and work contexts in which they occurred;
- are sufficiently senior within the organisation to secure the cooperation of other staff members;
- are familiar with the local policy for investigating concerns and related procedures;
- have, preferably, some training and experience in undertaking performance investigations;
- have access to relevant advice and expertise from colleagues within the organisation;
- have access to relevant external experts and authority to instruct them;
- have the necessary protected time to support the investigation.

The case manager should have no real or perceived conflict of interest in relation to any aspect of the investigation. Given the structure of the NHS and the small size of some organisations, minor conflicts of interest are difficult to avoid. Any reservations about the choice of a case manager ought to be reported to the DMG or responsible officer at the outset so that a decision can be made about their significance. The practitioner's views should also be taken into account.

In England, MHPS requires that the medical director should act as case manager for cases involving clinical directors and consultants.

3.3 Appoint case investigator(s)

Normal practice is for the investigative work to be carried out by a second senior staff member, or possibly more than one. An investigator's role is to collect and examine relevant evidence and complete the investigation in line with its terms of reference. The investigator will ask the practitioner for a response to the concerns raised, resolve any conflicts of evidence, determine the facts and produce a report which accurately captures all relevant details and findings. All investigators also have a duty to maintain confidentiality and ensure that the investigation is documented.

Usually investigators can be identified within the organisation but occasionally it is necessary to commission an external expert where a suitable person is not available internally. All investigators must be asked to confirm at the outset that there are no real or perceived conflicts of interest disqualifying them from doing the work in question. As for case managers, it may not be possible to identify an investigator totally without knowledge of the practitioner in some administrative capacity. As for case managers, any doubts about impartiality should be raised at the outset.

When asked to undertake an investigation, investigators should be able to demonstrate that they:

- have the necessary expertise to conduct the investigation. In the event that the nominated investigator does not have a relevant clinical background they should ensure that they obtain appropriate advice where issues of clinical judgement are raised. If there are no other senior clinicians with the relevant expertise, a senior clinician from another NHS body should be involved;
- understand the work context of the practitioner;
- have time to complete the investigation and report in a reasonable timescale.

Where more than one investigator is instructed, a lead investigator should be nominated to lead the investigation, ensure compliance with the terms of reference and complete the report.

3.4 Collect evidence

Evidence needs to stand up before an impartial tribunal. It includes written materials such as patients' clinical records and other organisation records, appraisals or other information held on the practitioner's personal file which is relevant to the investigation, as well as oral and written evidence provided by witnesses to specific events and any other relevant factual information. The practitioner is also a witness.

An investigation will often begin with a planning meeting between the case manager and investigator(s) to determine, for example:

- what documents need to be seen;
- who will be interviewed;
- how to manage administration of the investigation;
- means of communication with the practitioner;
- other logistical issues.

The investigating team will need to take a view on whether patient records need to be accessed to assist the investigation. Normally this will require prior patient consent but in certain circumstances there can be a public interest justification for disclosure without consent. It may be necessary to take advice from the organisation's Caldicott Guardian in the first instance, and possibly also from the organisation's legal advisers.

Once collected, evidence must be stored safely. Attempts to alter evidence can be prevented if original documents are obtained as soon as possible, and kept securely. Where it is necessary to give the practitioner access to documents, they should be provided as copies or viewed under supervision.

For guidance on conduct of interviews, including use of the PEACE model (Preparation and planning, Engage and explain, Account, Closure and Evaluation) go to: www.ncas.npsa.nhs.uk/toolkit/investigating/train-investigators/resources

The investigator should remain objective and avoid leading the witness through inappropriate feedback or comment. At the end of the interview the witness should be asked if there is anything else that they wish to add to the evidence that they have given. Following the interview, witnesses should be given a comprehensive note and asked to confirm that it is an accurate record of their interview. Alternatively, it is open to the healthcare organisation to commission its legal advisers to obtain a formal witness statement.

In general, there is no need for witnesses to be accompanied. If a witness requests a friend or supporter to be present, the investigators may allow this but the friend should take no part in the interview and should not answer questions or make statements on the witness's behalf.

Accurate records should be kept of all interviews. Interviewees may feel inhibited by the use of recording equipment. If recording is proposed, do not turn the equipment on until the interviewee has agreed to its use. Explain why you would prefer to use it, who will be entitled to listen to it and how long the recording will be retained before being erased. If the witness does not agree, have a note taken by a second person, so that the investigator can concentrate on asking questions.

See Box 5 for an example of how a witness statement might be set out. There are several ways of putting witness statements into writing. It may be appropriate for some witnesses to write their own statements. But it also acceptable for the investigator to question, take notes and then draft the witness statement, using the witness's own words so far as possible. The witness can then check the draft, ask for alterations to be made, if necessary, and sign the statement as an accurate record.

Box 5 – A witness statement format

Investigation reference number

Statement made by [witness] to [investigator] after interview on [date].

This statement was drafted on my behalf by [investigator] and I have confirmed its accuracy, having seen it in draft and having been given an opportunity to make corrections or additions.

The investigator told me the terms of reference of the investigation and asked me questions about [ ].

The investigator also showed me [ ] and asked me to comment on [ ] attached [ ] to this statement.

I said [facts of the case as known to the witness, in chronological order].

I said that [ ] also [observed the event in question] and could corroborate this statement.

I believe that the facts in this statement are true.

Signed

Date

3.5 Interview the practitioner

Precisely what information will be given to a practitioner under investigation will depend on the circumstances of the case and on any relevant rules, regulations and procedures governing its handling. The investigator must be free to collect evidence without being pressurised by the practitioner or the practitioner's representative.

Assuming it is appropriate for the practitioner to know that the investigation is taking place (that is, no advice against telling the practitioner has been given by the police or a fraud agency), the practitioner should be invited to provide any information thought relevant to the matters under investigation. This might include documentary evidence as well as identifying witnesses, and providing oral evidence. The investigator(s) should take account of

any evidence provided by the practitioner which is consistent with the investigation's terms of reference. It may be appropriate for the practitioner to be interviewed twice, at the start of the investigation (see also 1.3) and at the end when all other evidence has been collected. The first interview gives the practitioner an opportunity to comment on the investigation process while the second allows the practitioner to be questioned about information likely to be used in the investigation report.

Prior to being interviewed the practitioner might request sight of the evidence on which the investigator(s) propose to rely in their report. This would normally be permitted, once the evidence has been collated into its final form. England's MHPS says that the practitioner must be shown a copy of the investigator's report in capability cases but this is not a requirement in MHPS conduct cases. Local procedures will need to be clear as to what, if any, access the practitioner will be given to the investigator's report to correct any matters of factual error before its submission to the case manager for consideration.

The *Employment Relations Act 1999* gives employed practitioners the right to be accompanied by a union/professional body representative or by a work colleague. While that person might speak on behalf of the practitioner, the practitioner must answer any specific questions put to them about their own actions. Many organisations also allow a friend, partner or spouse to provide support to the individual in a similar manner. In England, where MHPS has been adopted, employed practitioners have an additional right to a legally qualified representative.

For practitioners whose cases are being investigated under Performers List Regulations, there are no statutory provisions on how an investigation should be conducted but it is good practice, where possible, to give such practitioners the same opportunities to be supported as employees.

A practitioner cannot be compelled to attend an investigation interview or answer questions but, in general, the only justification for declining to answer questions is that to do so would be incriminating. Failure to attend an interview or cooperate may in itself warrant further action. Professional regulators expect practitioners to cooperate and contribute to local inquiries to help reduce risk to patients, so regulator referral may be an option for the organisation where non-cooperation arises.

Not answering questions denies the practitioner the opportunity to ensure that their own account of events is properly presented to the investigators. The practitioner's own account of events might still be presented at any later hearing that might arise.

3.6 Weigh the evidence and identify the facts of the case

Having collected the evidence, the investigator(s) should set out the facts as they see them, weighing the evidence on the balance of probabilities and taking as true anything which appears more probable than improbable. The more serious the concerns about the practitioner, the greater the need for the investigators to satisfy themselves that the evidence supports their findings of fact.

Investigators will need to take positions on:

- **Written versus oral evidence:** while written evidence may be more clearly defined, oral evidence can be tested by questioning and could be taken as equally reliable, depending on the circumstances. Written witness statements are best compiled in the words of the witness and signed and dated. Both forms of evidence are best collected as soon as possible after the events in question.
- **Age of evidence:** apart from determining what is meant by 'old' in local proceedings, it might be considered that a pattern of unacceptable performance (including conduct) over a period of time is likely to be more significant evidence than an isolated incident even if occurring recently.
- **Seeing the event itself or seeing the aftermath:** factual evidence ought to carry most weight. Opinions of witnesses and unsupported anecdotal evidence are likely to have limited use.
- **Technical competence:** where the investigator identifies a need for specialist advice to interpret a technical issue outside their expertise, the case manager should make arrangements for it to be provided so that evidence is appropriately interpreted.

- **Evidence from previous investigations:** all relevant evidence should be considered, including previous complaints and investigations where relevant, provided there are adequate records of the events and actions that were taken at that time, or matters were of a serious nature such that they continue to have a relevance to the matters now under investigation and can usefully form part of the investigators' report.

In order to be able to demonstrate a fair process, if there is any uncertainty about how to treat a specific piece of evidence, advice should be sought from the healthcare organisation's legal adviser.

Some conflicts of evidence are probably inevitable as individuals present different accounts of the same events. Not all conflicts of evidence need to be resolved, only those that affect the investigators' findings of fact about the performance concerns being investigated.

Normally, independent accounts which corroborate each other are likely to be preferred to disparate accounts of the same incident, or similar accounts provided by people known to be antipathetic to the practitioner under investigation. In drafting their report, investigators should record material conflicts of evidence stating which version of events they preferred and why.

3.7 Manage the timetable

MHPS states that the case investigator should aim to complete the investigation within four weeks of appointment and submit a report to the case manager within a further five days. In more complex cases it may not be possible to do this. But it is good practice to try to complete investigations within a reasonable timescale taking into account the circumstances of the individual case. Delays are damaging to the healthcare organisation, the practitioner, and to other staff and patients. The investigation process can lose momentum and become stale. Active management of the process by the case manager is essential if delays are to be avoided.

Where key individuals are difficult to contact and interview, all reasonable steps should be taken to accommodate their other commitments. Case managers should receive the full support of senior management in overcoming any delays.

Practitioners who are unavailable should be given a reasonable opportunity to participate in the process, which may involve close liaison with their representative. The representative will be aware that failure to cooperate means that the practitioner's oral or written account of events may not be received by the investigators in time to influence the report.

Where a practitioner's current health status is preventing their participation in the investigation process, an occupational health assessment might be offered to ascertain whether, whilst they may not be fit to return to work, they are well enough to be interviewed.

All this adds up to a checklist for monitoring the investigation's progress, once started – see Box 6 (page 18).

Box 6 – Investigation checklist

	Responsibility	Date
Decision to investigate made	Decision-makers	
Practice restriction/suspension/exclusion considered	Decision-makers	
Case manager appointed	Decision-makers	
Investigator(s) appointed	Decision-makers	
Timetable finalised	Decision-makers	
Terms of reference finalised	Decision-makers	
Practitioner notified of decision to investigate	Case manager	
Practitioner notified of investigator arrangements	Case manager	
Meeting with practitioner to discuss arrangements	Case manager	
CEO told of arrangements made	Case manager	
Communication channels established (phone numbers etc)	Case manager	
Document requirements identified	Investigator	
Document storage system set up	Case manager	
Documents provided to investigator	Case manager	
Interviews identified	Investigator	
All interviews timetabled (including practitioner's)	Investigator	
First interview with practitioner completed (on process)	Investigator	
Note of first interview agreed	Investigator	
Interviews with other witnesses completed	Investigator	
Other witness notes agreed	Investigator	
Second interview with practitioner completed (on case)	Investigator	
Note of second interview agreed	Investigator	
Report in first draft for discussion with case manager	Investigator	
Report in second draft for accuracy check	Investigator	
Submission of report	Investigator	

4. Reporting

The final step is for the investigator to write a report – if possible within the five days suggested by MHPS. Like the rest of the investigation this will require dedicated time. The task will be easier if the case manager has organised a tight filing system to support the investigation. Consider the following:

- **documentation systems;**
- **the report;**
- **circulation;**
- **next steps.**

4.1 Documentation systems

At the end of the investigation the organisation ought to have a comprehensive record of the information gathered during the investigation, with transcripts and witness statements where applicable. It is the case manager's responsibility to ensure that the investigation is documented and that all information held is identified and retrievable.

Case records should be kept securely and remain confidential. Electronic and hard copy records are equally acceptable. They should be handled in accordance with local and national data management requirements set out in the *Data Protection Act 1998* and the *NHS Code of Practice on Confidentiality* (Department of Health 2003). There is no nationally-set rule on retention periods for investigation records so organisations will need to determine their own retention periods for case documentation, taking into consideration local policies on, for example, retention of employment records.

During an investigation the practitioner may request access to relevant case papers, such as original clinical records which may form the basis of any questions to be posed by the investigator. It would be normal for such requests to be met.

4.2 The report

The key document is the investigator's report. This should be a self-contained document with enough information within it to inform a subsequent decision on whether concerns are unfounded or confirmed, whether or not further action is needed and, if so, the type of action to be taken.

The decisions would be made by a decision-making group of some description (in primary care) or (elsewhere) by the responsible manager in consultation with relevant senior colleagues and on the advice of the case manager. In primary care, available actions would be as provided for in performers list regulations. Elsewhere, action would either be under capability or conduct procedures, and the investigation would need to discuss the relevance of each of these procedures.

Wherever possible the report should exclude reference to identifiable individuals other than the practitioner. A suggested structure for an investigation report is shown in Box 7 (page 20). It will not be appropriate for every investigation but it shows how evidence can be set out in order to be as clear as possible and inform the decision-making process effectively.

Box 7 – A report template

Front cover
Strictly confidential

Organisation name

Report of investigation into concerns raised in relation to [practitioner's name and address]

Organisation's case reference number

Date

Contents page
Chapter headings with page numbers. Headings might include: Introduction, Background, The investigation, Methods, Findings of fact, Summary of conclusions.

The report can refer to annexes as necessary. Each document referred to should have a unique identifier. Where there are many documents it is helpful to categorise them by type – witness statement, clinical record, summary of witness interview, etc. The system will follow from the filing system set up at the start of the investigation.

Report
The report needs to set out the case story. The sections which will be appropriate will depend on the nature of each case but the following elements will normally need to be included somewhere:

- **Introduction:** brief introduction to the investigation, its relationship with any investigations by other bodies and the procedures and regulations governing the present investigation.
- **Background:** relevant career information about the practitioner and work with the organisation, with reasons for the investigation in more detail.
- **The investigation:** the specific allegations for investigation, the team carrying out the investigation (with names, job titles and qualifications), the terms of reference as set initially plus any subsequent amendments.
- **Methods:** for example, review of patient records, audit of a specific set of cases, prescribing reviews, interviews with specified patients and/or colleagues. If any expert witnesses were used, their expert credentials should be reported. There should be a list of all people interviewed and the capacity in which they were involved in the investigation.
- **Fact-finding:** what has happened, set out in chronological order and with supporting evidence identified. Where the fact-finding include the opinion of case investigators or other experts on a standard of care, the required standards of care should be quoted. The findings should draw attention to any conflicts of evidence and whether it was necessary to resolve the conflicts in order to complete the investigation. Grounds should be given for preferring one version of events to another.
- **Conclusions:** the conclusions reached on each of the points listed in the terms of reference, cross-referenced to the findings of fact.

Signed [Investigator(s)]

Date

4.3 Circulation

Circulation of the investigator's report is normally limited to the practitioner, case manager, members of the DMG (in primary care) or the responsible manager (elsewhere). In addition, and once appointed, a copy should also go to the responsible officer in England, Wales and Scotland. The DMG or the responsible manager may, at their discretion, consider whether it would be reasonable for the report subsequently to be seen by others.

The report should remain confidential. Where disclosure to any other person or body is deemed appropriate, disclosure should be kept to the necessary minimum and limited to specified individuals or bodies who are themselves under a duty of confidentiality about the information.

4.4 Next steps

At the conclusion of the investigation it is for the DMG or the responsible manager to determine what further action, if any, is required. There are many potential options, ranging from taking no further action or arranging local counselling and mentoring, to referral to the regulator or use of local disciplinary or capability procedures.

Once a decision has been reached the case manager should arrange to meet the practitioner to explain the outcome of the investigation. It remains open to the healthcare organisation to contact NCAS for further advice at any stage.

Glossary

Alert notice
Alert notices are used where a practitioner is believed to pose a serious potential or actual risk to patients or staff and who is believed likely to be working or seeking work elsewhere in a health or social care setting. See www.ncas.npsa.nhs.uk/toolkit/disciplining/consider-who-else-needs-to-know for advice on use of alert notices.

Area Professional Committees
In Scotland, Area Professional Committees are the statutory representative bodies for local practitioners. They are the equivalent of local representative committees in England, Wales and Northern Ireland.

Balance of probabilities
The balance of probabilities is the standard of proof required in most civil proceedings. It is met if allegations appear more likely to be true than not true.

Case investigator
A case investigator examines the relevant evidence in line with an investigation's terms of reference, determining findings of fact and producing a report.

Case manager
A case manager coordinates the investigation, organises its administrative support and tries to ensure that the investigation is completed to a timetable.

Clinical records
Clinical records include any information relating to the care or treatment of any current or former patient, including notes made by clinical staff, correspondence between clinicians, clinical photographs, video and audio recording, pathology results.

Confidentiality
Confidentiality is a legal obligation as well as a requirement of professional codes of conduct. It is also a specific requirement within NHS employment contracts and breaching confidentiality can lead to disciplinary action.

Counter fraud agencies
The NHS Counter Fraud and Security Management Service in England and Wales, and equivalent bodies in Northern Ireland and Scotland.

Decision-making group (DMG)
While procedures in primary care organisations vary, there will usually be a two-tier structure, with a performance advisory group (PAG) and a decision-making group (DMG). See NCAS guidance, *Handling performance concerns in primary care* (2010).

Defence societies
Amongst a range of member services, defence societies advise practitioners whose performance has caused concern.

Duty of cooperation
Practitioners have a professional and usually also a contractual responsibility to cooperate with investigations into standards of care and related issues. Only if cooperation could lead to incrimination are practitioners entitled to decline to answer questions.

Evidence
Evidence is the totality of the information relevant to the investigation to establish the facts about events. Evidence will come from a variety of sources and may be written or oral and in paper or electronic format.

Exclusion from the workplace
Exclusion from the workplace requires employees not to undertake their normal contractual responsibilities, usually on a temporary basis pending investigation and consideration of necessary further action. It is a precautionary measure, not a disciplinary sanction.

Fair process
Fair process means that the proceedings are conducted in a way that ensures that both sides have an opportunity to see and challenge all the evidence.

Lead investigator
See also 'Case investigator'. Where more than one case investigator is appointed, a lead investigator should be identified with responsibility to ensure that the investigation is completed as required under its terms of reference.

Local investigation
An investigation instigated and conducted by the organisation where the practitioner is working, as distinct from an investigation by a professional regulator, for example.

Local performance investigation procedure
A procedure published by the organisation and governing the conduct of local performance investigations.

Local representative committee
A generic term describing local dental committees, local medical committees, local pharmacy committees and also local optical committees. These are the groups representing the interests of primary care practitioners.

Look-back exercise
A retrospective review of the care provided to patients to determine if advice or treatment given was correct and safe, and whether further advice, investigation or treatment is required in response to any shortcomings identified during an investigation.

NHS Tribunal (Scotland)
The NHS Tribunal (Scotland) is an independent body established to ensure that NHS primary care services are not brought into disrepute by practitioners committing fraud, prejudicing its efficiency or similar behaviour.

Occupational health assessment
Occupational health services advise organisations and practitioners on work-related health issues, including advice on the effects of identified conditions on a practitioner's ability to perform certain roles and on general fitness to work.

Patient safety
Processes and procedures put in place to prevent avoidable harm to patients, including the identification of performance concerns about practitioners.

Performance advisory group (PAG)
A group giving expert advice on performance handling within a primary care organisation. See also 'Decision-making group'.

Performance assessment
Where local investigation has not produced enough information to identify a clear way forward, the organisation may consider a performance assessment. Assessments are undertaken by different bodies for different purposes. For information about NCAS assessments go to www.ncas.npsa.nhs.uk/about us/whatwedo

Performance investigation
A performance investigation to determine whether or not there is a performance problem to be addressed. An investigation is not an assessment.

Personal conduct
Personal conduct includes aspects of behaviour that apply to all healthcare staff and include honesty, punctuality, civility, respect for patients and co-workers etc. See also 'Professional conduct'.

Professional conduct
Professional conduct describes the expected standards of behaviour for healthcare professionals. It includes all aspects of providing care for patients, working with colleagues and in teams, respecting the contribution of other health professionals, maintaining confidentiality and high professional standards.

Public Concern at Work Policy
A policy published by the organisation setting out the responsibility of employees and other to notify the responsible manager of concerns about patient safety or other matters threatening to undermine the integrity of the service. See also 'Whistleblowing'.

Public Interest Disclosure Act 1998
This Act provides some protection from dismissal and victimisation to employees raising genuine concerns about performance or conduct. In certain circumstances it will also provide redress.
See www.opsi.gov.uk/acts/acts1998/ukpga_19980023_en_1

Regulators
Regulators are statutory bodies responsible for the regulation of groups of health professionals and for establishing that practitioners are fit to practise. The General Dental Council, General Medical Council and General Pharmaceutical Council are all regulators.

Responsible manager(s)
A responsible manager decides what actions should be taken in response to a performance concern, on behalf of an organisation. This might include a decision to hold an investigation. The responsible manager will also decide the actions to be taken once an investigation is complete. It is common for the medical director or equivalent to fill this role.

Responsible officer
All practising doctors in England, Scotland and Wales are to be required to relate to a local 'responsible officer'. This will be a senior doctor with local responsibility for overseeing the revalidation process and handling complaints against doctors.

Restrictions on practice
A requirement or formal undertaking to limit professional practice to specific agreed areas or to define specific exclusions.

Separation of roles
No person involved in one stage of an investigation should take part in subsequent disciplinary proceedings or appeals based on the same set of facts. Separation of roles is an important element of securing fair process.

Soft information
Soft information does not have a firm evidential basis but nevertheless may contribute to the evaluation of concerns, if credible.

Suspension
Suspension is used in this guidance to describe an NHS procedure involving temporary removal of a practitioner from a performers list which prevents them performing the relevant list activities. It does not restrict their ability to practise in other settings. Only the regulator has the power to restrict registration pending investigation and further review. In all cases the on-going need to maintain a suspension must be kept under regular review. Note that terminology is not consistent across the UK, however, and 'suspension' sometimes describes 'exclusion' from employment.

Terms of reference
Terms of reference define the nature and purpose of an investigation, documenting its scope – what is included and what is excluded.

Whistleblowing
Whistleblowing means the raising of concerns outside normal organisation procedures because attempts to use the procedures appear to have failed. All organisations should have whistleblowing policies and procedures in place.

Witness
A witness of fact has first-hand knowledge about the event(s) in question and can help clarify issues for the investigators. An expert witness has specialist knowledge and can assist in the interpretation of events, standards of care or other relevant issues.

Other bodies who may be involved in performance investigation

Although most performance concerns can be investigated locally, some will require swift referral to the other agencies. NCAS can give advice on the appropriateness of referral to another body.

General Dental Council	www.gdc-uk.org CAIT@gdc-uk.org 0845 222 4141
General Medical Council	www.gmc-uk.org practise@gmc-uk.org 0845 357 0022
Royal Pharmaceutical Society of Great Britain (until General Pharmaceutical Council operational)	www.rpsgb.org enquiries@rpsgb.org 020 7735 9141
Pharmaceutical Society of Northern Ireland	www.psni.org.uk 028 9032 6927
General Pharmaceutical Council (expected to be operational Spring 2010)	www.pharmacyregulation.org 020 3365 3400
Family Health Services Appeal Authority	www.fhsaa.tribunals.gov.uk 0113 389 6061
Counter Fraud and Security Management Service	www.nhsbsa.nhs.uk/fraud 020 7895 4500
Counter Fraud and Probity Services Northern Ireland	www.hscbusiness.hsc.net 028 90 535574
NHS Scotland Counter Fraud Services	www.cfs.scot.nhs.uk 08000 15 16 28
Health Service Ombudsmen for England, Northern Ireland, Scotland and Wales	www.ombudsman.org.uk 0345 015 4033 www.ni-ombudsman.org.uk 0800 343424 www.spso.org.uk 0345 015 4033 www.ombudsman-wales.org.uk 01656 641150

At a glance

Deciding to investigate:

- What has happened? Is it isolated or are there linked incidents?
- What is the evidence and how much of it is corroborated?
- Are any other agencies involved? Should they be?
- Are there any health issues?
- Are there any patient safety or wider public interest protection issues that leave patients at risk?
- Which local procedures would govern an investigation?
- What would the terms of reference be? What might be included and excluded?
- Do we have trained investigator(s) available?
- What would the timescale be?
- Would an investigation report help us decide what to do next?

Questioning:

- Interview out of public gaze
- Frame questions around the concern(s) defined in the terms of reference
- Tell witnesses that it may be necessary to share the information provided
- Ask witnesses to corroborate or refute, based on what they themselves know
- Ask witnesses to sign off their statements

Reporting:

- Explain how the investigation came about and what has been done so far to manage the concern
- Identify the procedures which the investigation has complied with
- List the investigating team
- List witnesses
- List findings of fact
- Discuss any conflicting evidence and explain how conflicts were resolved

The National Clinical Assessment Service (NCAS) works with health organisations and individual practitioners where there is concern about the performance of a dentist, doctor or pharmacist.

We aim to clarify the concerns, understand what is leading to them and support their resolution. Services are tailored to the specific case and can include:

- expert advice and signposting to other resources;
- specialist interventions such as performance assessment and back-to-work support.

NCAS uses evaluation, data analysis and research to inform its work and also runs a programme of national and local educational workshops. Employers, contracting bodies or practitioners can contact NCAS for help. NCAS works throughout the UK and associated administrations and in both the NHS and independent sectors of healthcare.

Contact NCAS

In England **call 020 7062 1655**

In Scotland **call 0131 220 8060**

In Northern Ireland or Wales **call 029 2044 7540**

www.ncas.npsa.nhs.uk

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